

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be reigned by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb 4 MO.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Randolph Hills Nursing home		e. STREET ADDRESS 3123 Brooklawn Terrace		
3. NAME OF DECEASED (Type or print) Peter		4. DATE OF DEATH Last Addis	Month Year Dec 28 1967	
S. SEX M	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED WIDOWED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/27/1880	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME Isaac Addis		11. BIRTHPLACE (County & State, or foreign country) New York		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		14. MOTHER'S MAIDEN NAME Unknown		
16. SOCIAL SECURITY NO. 043-26-4227		17. INFORMANT Wife Beatrice Addis Same as Item 2.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper respiratory infection viral + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 475x (b) Escherichia coli DUE TO (c) 4 days. DUE TO				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8P M.	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 26 , 19 67 , to Oct 18 , 19 67 that (I) (we) last saw the deceased alive on Nov 8 19 67 , and that death occurred at 8P M. from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
22a. SIGNATURE A. J. Connally		M.D. <input type="checkbox"/> ATTENDING PHYS. A. J. CONNALLY MD	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-28-67
22c. PHYSICIAN'S NAME (Type) A. J. CONNALLY MD		22d. ADDRESS 1635 IRVINE ST. X-66 WASH. D. C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-30-67	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven	23d. LOCATION (City or Town) Silver Spring Mont Md (County) (State)
24. FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 7557 Wisconsin Ave Bethesda, Md		25a. REC'D BY REGISTRAR DATE JAN 5 1968
				25b. REGISTRAR'S SIGNATURE Charles George

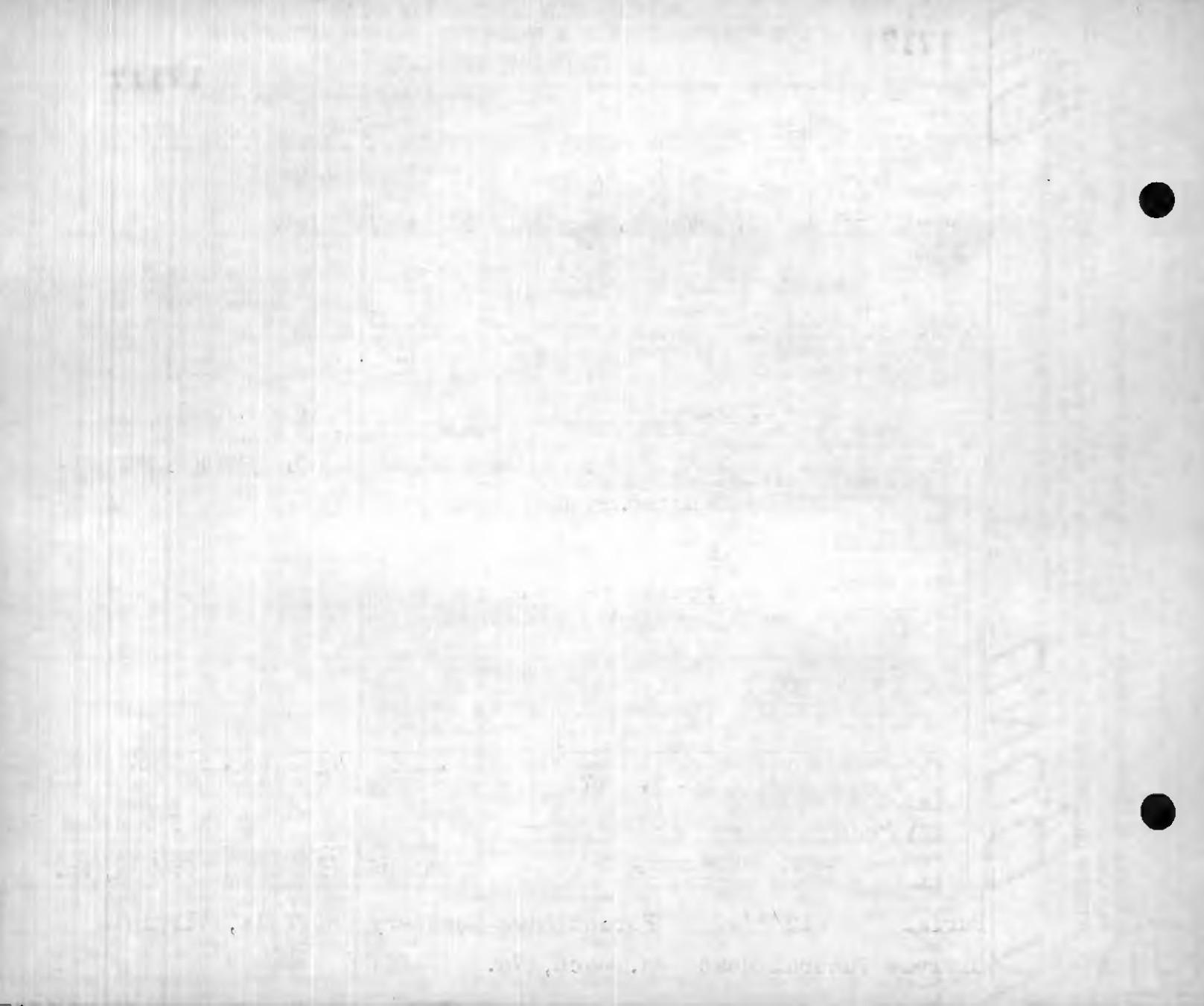


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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Virginia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. LENGTH OF STAY IN 1b 4 days					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Virginia Beach						d. STREET ADDRESS 312 Hospital Drive					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Jacqueline	Middle Lois	Last Akers	4. DATE OF DEATH December 5 1967	Month December	Day 5	Year 1967			
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 July 1959	9. AGE (In years lost birthday) 8 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Wayne J. Akers						14. MOTHER'S MAIDEN NAME Lois V. Hall					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency INTERVAL BETWEEN ONSET AND DEATH 4 days 2873 DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Pneumonia 4 days DUE TO { (c) Cystic Fibrosis of the Pancreas 8 Years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 1, 1967 to Dec. 5, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 5, 1967 , and that death occurred at 9:43 M. from causes and on the date stated above.											
22a. SIGNATURE Stuart Handwerger AM M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 5 December 1967											
22c. PHYSICIAN'S NAME (Type) Stuart Handwerger, MD			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/8/67			23c. NAME OF CEMETERY OR CREMATORIAL Forest Lawn Cemetery			23d. LOCATION (City or Town) (County) (State) Norfolk, Virginia		
24. FUNERAL DIRECTOR Simiele Funeral Home			ADDRESS Va. Beach, Va.			25a. REC'D BY REGISTRAR DEC 8 1967			25b. REGISTRAR'S SIGNATURE Charles J. George		



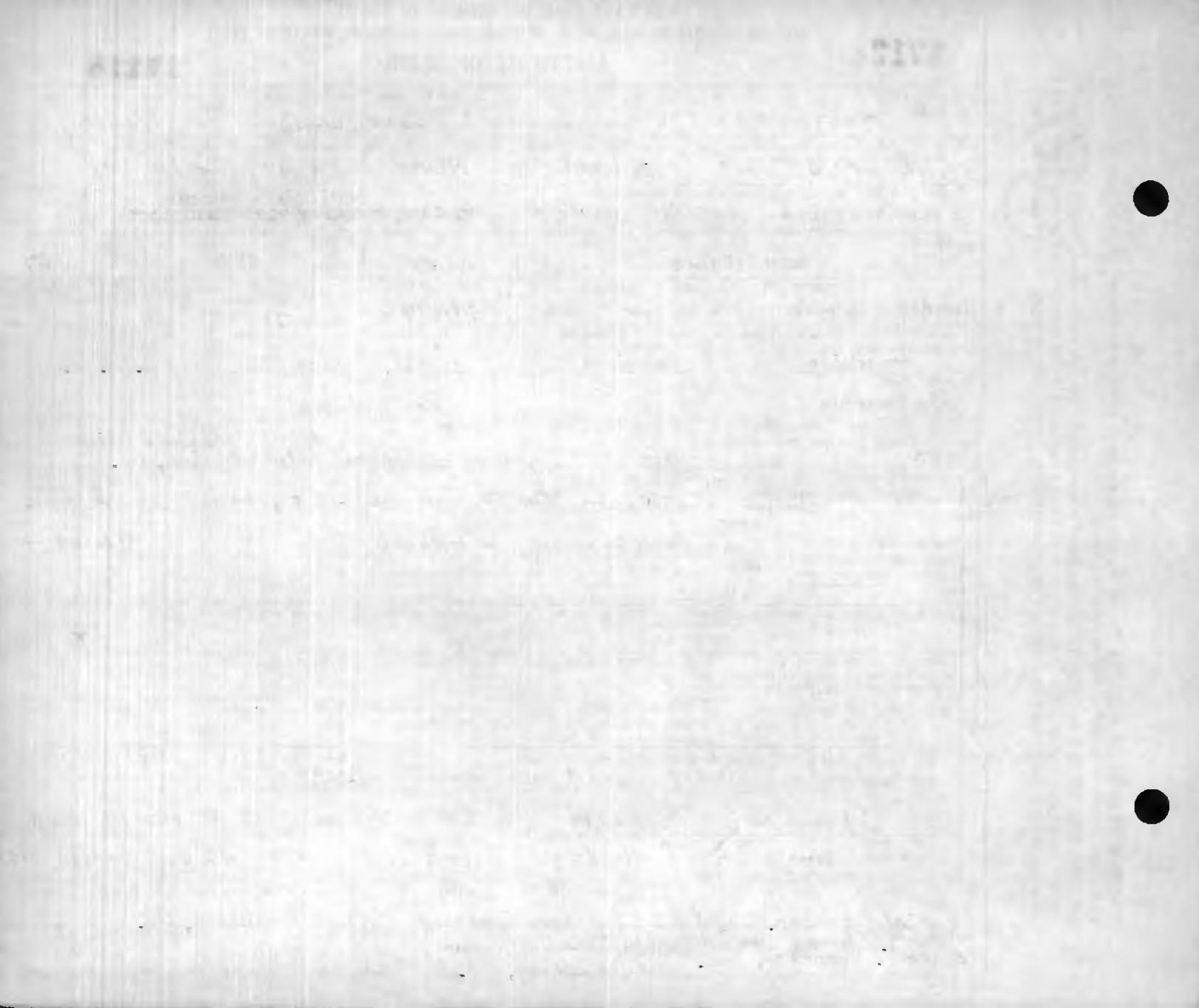
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CERTIFICATE OF DEATH

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To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper, sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours of death.

17122		17118	
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING, MD.		c. LENGTH OF STAY IN lb 3 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) COLONIAL VILLA NURSING HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING, MARYLAND 15-1	
d. STREET ADDRESS 8403 Dixon Avenue KESBXXXXXXCHAMPSHIRE AVENUE		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
g. DATE OF DEATH Month DEC. Day 19 Year 1967			
3. NAME OF DECEASED (Type or print) First CHRISTINE Middle (NONE)		4. DATE OF DEATH Month DEC. Day 19 Year 1967	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4/16/96		10. AGE (In years from last birthday) 71 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Trinoli, Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Manetas		14. MOTHER'S MAIDEN NAME Mary (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Helen Sonidakes		Address 10702 Woodsdale Drive Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CANCER IN LUNGS, CAUSE? DUE TO 163 X		INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) PANCREATITIS, CHRONIC DUE TO (c)		9 MONTHS	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 1962, to 12/19, 1967, that (II) (we) last saw the deceased alive on 12/19 1967, and that death occurred at 1230 P.M. from causes and on the date stated above.			
22a. SIGNATURE James A. Roberts		22b. DATE SIGNED DEC. 19, 1967	
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS		22d. ADDRESS 8907 GEORGIA AVE. SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 22, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL PARKLAWN CEMETERY		23d. LOCATION (City or Town) (County) (State) Rockville, Md.	
24. FUNERAL DIRECTOR John E. Thomas, Huber's Georgia Avenue Warren E. Humphrey, Inc. Silver Spring, Md.		25a. ADDRESS 2421 Georgia Avenue	
		25b. REC'D BY REGISTRAR DATE DEC 27 1967	
		25b. REGISTRAR'S SIGNATURE James A. Roberts	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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NO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE	
Montgomery		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Chevy Chase		18 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
4120 Stanford St		4120 Stanford St	
3. NAME OF DECEASED (Type or print)		First	Middle
		Last	
4. DATE OF DEATH		Month	Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
M		W	
8. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
Feb 22, 1910		57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
electrical engineer		Gov.t.	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Wharton, Texas		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
MAX Alexander		Minnie Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or No <input type="checkbox"/> or Unknown <input type="checkbox"/>)		16. SOCIAL SECURITY NO.	
and		013-05-6897	
17. INFORMANT		Address	
Mrs. Eleanor Alexander			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Adenocarcinoma of the Stomach	
151X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)	4 years
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)
19			20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1963, to Dec 9, 1967, that (I) (we) last saw the deceased alive on Dec 8 1967, and that death occurred at 9 ³⁰ AM, from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
William Harvey		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	12/9/67
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
William Harvey		2121 Penn Ave N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		12/11/67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)	
King David Memorial Park		Falls Church, Virginia	
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.		25a. REC'D BY REGISTRAR	
5130 Wisconsin Ave. N.W. Washington, D.C.		25b. REGISTRAR'S SIGNATURE	
		Charles Judge	
		DATE DEC 15 1967	

517

1. small cat the black cat
2. small white mouse
3. small bird the small bird
4. small worm the worm
5. small fly the fly
6. small ant the ant



FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your file.

TO FINISH DIRECTIONS: Boss 3 should have already been defeated for your files.

Ministère de l'Éducation

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17120

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING, MD.		c. LENGTH OF STAY IN 1b 2½ hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		d. STREET ADDRESS 3229 University Blvd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First AHMED	Middle	Last ALHASHIMI	4. DATE OF DEATH	Month 12	Doy 12	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/62	9. AGE (In years last birthday) 5 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0 Hours 0 Min. 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IRAQ		12. CITIZEN OF WHAT COUNTRY? IRAQ	
13. FATHER'S NAME KHALID ALHASHIMI		14. MOTHER'S MAIDEN NAME unobtainable					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. A. Youssef - Kensington, Md.		Address 4009 Dearfeld Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812.4 DUE TO (b) Multiple extreme Injuries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) including fractured skull and cerebral laceration		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child ran into street in front of auto and was struck					
20c. TIME OF INJURY Month, Day, Year 11:50 p.m. 12-12-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, foreign street, office, etc.) Street		(City or town) Kensington (County) Montgomery (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reep		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED Dec. 12, 1967	
EXAMINER'S NAME (Type) BELDEN R. REEP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12/14/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS National Mem. Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR The H. Hines Co.		25a. REC'D BY REGISTRAR DATE DEC 15 1967		25b. REGISTRAR'S SIGNATURE Jeanne Judge			

ACT 2

4212

the first time I have seen a man
so well educated and so well informed
on all subjects.

I am very sorry to hear of your illness
but I hope you will soon be well again.

I am sending you a copy of the "Daily
Telegraph" which contains some very
interesting articles.

I am sending you a copy of the "Daily
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interesting articles.

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125

CERTIFICATE OF DEATH

17121

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>			d. STREET ADDRESS <u>2411 Darrow Street</u>		
e. NAME OF DECEASED First <u>HAZEL</u> Middle <u>WREN</u> Last <u>ALLEN</u>			4. DATE OF DEATH Month <u>Dee.</u> Day <u>27</u> Year <u>1967</u>		
5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-1899</u>
			WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>67 8 mos</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Christiansburg, Virginia</u>		
13. FATHER'S NAME <u>Noah C. Allen</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>578-07-5110</u>		
17. INFORMANT <u>A Thomas J. Allen Silver Spring, Md.</u>			Address <u>2411 Darrow Street</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Shock</u>			INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Hypertension</u>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Prince Georges Co.</u> (County) <u>Md.</u> (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>12/27/67</u> , that (we) lost <u>her</u> (we) lost <u>sow</u> the deceased alive on <u>12/27/67</u> , and that death occurred at <u>3 A.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Norman H. Rubenstein</u>			22b. DATE SIGNED <u>12/27/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Norman H. Rubenstein</u>			22d. ADDRESS <u>11161 New Hampshire Avenue, S. S. ride</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Port Lincoln Cemetery</u>	23d. LOCATION (City or Town) <u>Prince Georges Co.</u> (County) <u>Md.</u> (State) <u></u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>		ADDRESS <u>10134 C. Glen Carter, Silver Spring, Md.</u>		25d. REC'D BY REGISTRAR <u>Charles Judge</u>	25e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
20 A15 14 20 M 1/66		DATE JAN 4 1968			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN 1b <i>7 Months</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	b. COUNTY <i>Montgomery</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Colonial Villa Nursing Home</i>	d. STREET ADDRESS <i>702 Venice Drive</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Gertrude BELLE Andrews</i>	First <i>Gertrude</i>	Middle <i>BELLE</i>	Last <i>Andrews</i>
4. DATE OF DEATH <i>12 5 1967</i>	Month <i>12</i>	Day <i>5</i>	Year <i>1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Sept. 20, 1871</i>	9. AGE (In years lost birthday) <i>96 yrs.</i>	10. IF UNDER 24 HRS Months <i>0</i>	YEAR Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Ohio</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>218-54-5276</i>	17. INFORMANT <i>Daughter - Mrs. Thos. Perkins</i>	Address <i>702 Vanus Dr.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<i>Cardiac Decompensation</i>	
		<i>Cardiosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <i>Hypertension</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>None</i>		(County) (State) <i>None</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>1966</i> to <i>5 Dec 1967</i> , that (I) (we) last saw the deceased alive on <i>4 Dec 1967</i> and that death occurred at <i>7:35 AM</i> from causes and on the date stated above.			
22a. SIGNATURE <i>William D. Andrews</i>		22b. DATE SIGNED <i>12/5/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>William D. Andrews</i>		22d. ADDRESS <i>9006 Colesville Rd. Silver Spring, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/7/1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>George Washington Cemetery</i>
23d. LOCATION (City or Town) <i>None</i>		(County) (State) <i>None</i>	
24. FUNERAL DIRECTOR <i>W.W. Chambers, Inc. Silver Spring, MD.</i>		25a. ADDRESS <i>None</i>	25b. REC'D BY REGISTRAR DA <i>DEC 7 1967</i>
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17123

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rensington</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>New York</i> b. COUNTY <i>Dutchess</i>	
c. LENGTH OF STAY IN 16 <i>18 Months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Red Hook</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Cottage Hill Nursing Home</i>		d. STREET ADDRESS <i>Red Hook, N.Y.</i>	
3 NAME OF DECEASED (Type or print) <i>Adelaide Elting</i>		First <i>Adelaide</i>	Middle <i>Elting</i>
		Last <i>Arnold</i>	4 DATE OF DEATH <i>December 30</i>
S. SEX <i>F</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <i>May 15 1882</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Honore</i>	9 AGE (In years last birthday) <i>83 yrs</i>
13. FATHER'S NAME <i>Henry S Elting</i>		14. MOTHER'S MAIDEN NAME <i>Sara J. Pitcher</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Elting Arnold, 4919 Dorset Ave., Chase, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary Insufficiency</i>		INTERVAL BETWEEN DEATH AND DEATH <i>24 hr.</i>	
Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Cardio-Vascular Disease</i>		YEARS <i>Years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20c. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>p.m.</i> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) <i>Bethesda</i> (County) <i>Maryland</i> (State) <i>M.D.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, had an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, BURIED <i>Buried</i>	23b. DATE THEREOF <i>1-3-68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>St James Cemetery</i>	23d. LOCATION (City, Town, County, State) <i>Hedge Park New York</i>
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>	7557 ADDRESS <i>Wisconsin Ave</i>	25a. REC'D BY REGISTRAR <i>DADAN</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
Bethesda, Md			
Date <i>5 1968</i>			

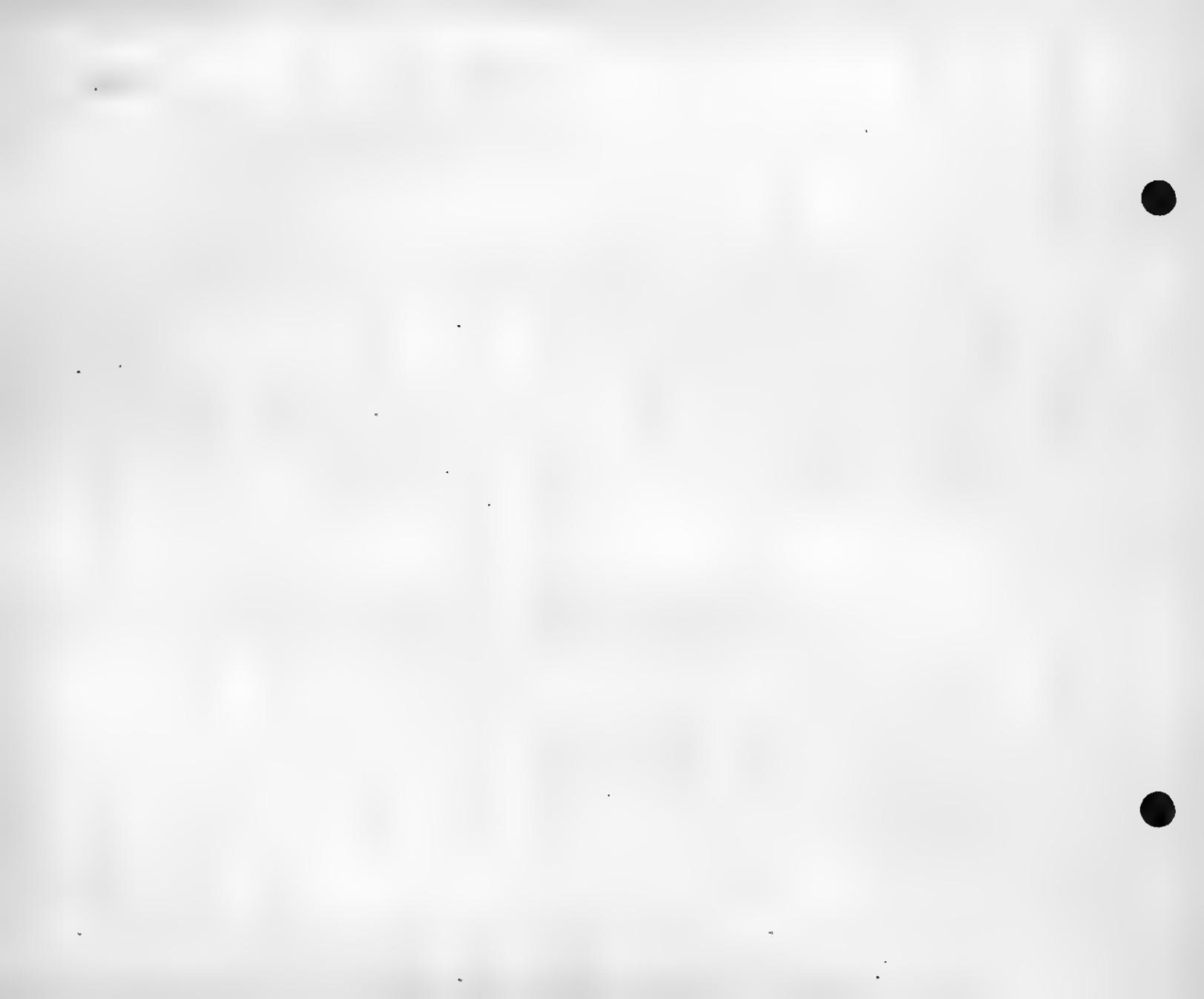


MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages and forms should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring,</i>		c. LENGTH OF STAY IN lb <i>26 years</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>9210 Flower Avenue</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>9210 Flower Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Rosalind</i>		First <i>Moore</i>	Middle <i>Rain</i>
4. DATE OF DEATH Month <i>December</i>		Day <i>20</i>	Year <i>1967</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <i>Dec. 13, 1867</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dentist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>	9. AGE (In years last birthday) <i>98 yrs</i>
13. FATHER'S NAME <i>Joseph B. Moore</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D. C.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes</i>	17. INFORMANT <i>David P. Moore</i>
			Address <i>9210 Flower Avenue Silver Spring, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Several hours</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Generalized arterio sclerosis</i>		Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>None</i>		(County) <i>None</i>	
(State) <i>None</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>1966</i> , to <i>December 20, 1967</i> , that (I) (we) last saw the deceased alive on <i>December 20, 1967</i> , and that death occurred at <i>9:40 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Bennet A. Porter Jr. M.D.</i>		22b. DATE SIGNED <i>December 20, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Bennet A. Porter, Jr. M.D.</i>		22d. ADDRESS <i>9301 Colesville Rd., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Entombed in it</i>		23b. DATE THEREOF <i>Dec. 23, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Mausoleum</i>
24. FUNERAL DIRECTOR <i>John B. Thomas</i>		ADDRESS <i>8434 Morris Avenue</i>	25a. REC'D BY REGISTRAR <i>Prince Georges Co. Md.</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles J. George</i>
20 M 1/66		D.F.C. 27 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kokomville</i>		c. LENGTH OF STAY IN lb <i>2 mos</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. STREET ADDRESS <i>5801 Nakagan Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Delia Ferrari Baldaccini</i>		First	Middle
4. DATE OF DEATH Month <i>12</i>		Month <i>14</i>	Doy Year <i>1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>9-24-1882</i>		9. AGE (In years last birthday) <i>85 yrs</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Italy</i>	
13. FATHER'S NAME <i>Carlo Ferrari</i>		14. MOTHER'S MAIDEN NAME <i>Felicitia Cherubini</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>578-68-7321-51</i>	
17. INFORMANT <i>Keo Goss-Daughter- See Item No. 9</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebral Atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 14</i> , 1967 to <i>Dec 14</i> , 1967, that (I) (we) last saw the deceased alive on <i>Nov 14</i> , 1967, and that death occurred at <i>139 M</i> , from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>Robert Macon</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/14/67</i>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-16-1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Md</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>		25a. REG'D BY REGISTRAR <i>DECEMBER 18 1967</i>	
25b. ADDRESS <i>5130 Wisconsin Ave. N.W. Washington, D.C.</i>		25c. REGISTRAR'S SIGNATURE <i>Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17126

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1, and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

Cashed with medical Examiner

1 PLACE OF DEATH Montgomery County		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c LENGTH OF STAY IN 1b 1 hr. 20 min.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San + Hosp.		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nyatt.	
d STREET ADDRESS 7610 - 25th ave.		f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) EVA		First	Middle
3 SEX F		6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY -	
11 BIRTHPLACE (County & State, or foreign country) Canada		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Martell		14 MOTHER'S MAIDEN NAME Amanda Tourpin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16 SOCIAL SECURITY NO 212-56-2421	
17 INFIRMANT Martha Petrone - dgt.		Address Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
DUE TO 4201			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { Coronary Thrombosis lost		DUE TO 2 hr.	
DUE TO (b) HyperTensive arteriosclerotic CVD.		DUE TO 18 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED Where at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 1955, 19 to 12-27, 1967 , that (1) (we) last saw the deceased alive on 12-20 1967 , and that death occurred at 12-27, 1967 from causes and on the date stated above.		22d DATE SIGNED 12-27-67	
22a SIGNATURE R.D.Bauer M.D.		22d ADDRESS 2513 Buck Lodge Rd. Adelphi, Md.	
22c PHYSICIAN'S NAME (Type) R.D.Bauer, M.D.		23a LOCATION (City or Town) Suitland, Md.	
23b BURIAL, CREMATION, REMOVAL (Specify) Burial		23c DATE THEREOF 12/30/67	23d NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a ADDRESS Mt. Rainier, Maryland JAN 5 1968	
		25b REC'D BY REGISTRAR REGISTRAR'S SIGNATURE	
		DATE 6 6	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 16 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY		First	Middle
4. DATE OF DEATH December 8, 1967		Month	Year
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 3/10/198
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAILER		10b. KIND OF BUSINESS OR INDUSTRY GROCER	
11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? A.S.A.	
13. FATHER'S NAME MORRIS		14. MOTHER'S MAIDEN NAME LEAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-07-8425	
17. INFORMANT Martin Baltrotsky		Address 1801 Arcola Ave. Silver Spring,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Final Pneumococcal pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes		5 years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic bronchitis, hypertension, obesity.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec. 4, 1967 , to Dec. 8, 1967 , that (I) (we) last saw the deceased alive on Dec. 8, 1967 , and that death occurred at 3:00 PM , from causes and on the date stated above.		22b. DATE SIGNED 12/9/1967	
22a. SIGNATURE R. Stein		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. ADDRESS 8641 Coleridge Rd, Silver Spring, Md
22c. PHYSICIAN'S NAME (Type) BLAINE H. STEIN		23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 10, 1967	23c. NAME OF CEMETERY OR CREMATORIAL King David Memorial Garden
24. FUNERAL DIRECTOR Hebrew Memorial Funeral Home		ADDRESS 232 Carroll St., N.W.-Wash., D.C.	25a. REC'D BY REGISTRAR Hebe 12 1967
			25b. REGISTRAR'S SIGNATURE Hebe 12 1967



FOR STATE
HEALTH DEPT

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Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the

funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17128

1. PLACE OF DEATH a. COUNTY Montgomery County		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b Hrs. Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		e. STREET ADDRESS 7333 New Hampshire Ave	
3. NAME OF DECEASED (Type or print) Ernest		First P.	Middle Barbour
4. DATE OF DEATH Month 12		Day 25	Year 1967
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 1910 5/25/1910
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months 0	
11. IF UNDER 24 HRS Days 0		12. COUNTRY USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. Prtg. Office	
13. FATHER'S NAME Philip J. Barbour		14. MOTHER'S MAIDEN NAME Ida G. Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO 216-44-9552	
17. INFORMANT Mrs. Mary Bennett - Sister-in-law		Address 7300-Birch Ave., Tak. Pk., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 194 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Multiple Extreme Internal Injuries with Exsanguination	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED After hour of injury in part II of item 18 deceased, driver, hit median strip lost control of car & struck pole	
20c. TIME OF INJURY Month, Day, Year 10 AM, 12-24-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm factory, school, office, etc.) street		20f. (City or town) Hyattsville, Md.	
21. I certify that I took charge of the remains described above, had an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Beal M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. BEAL M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED DEC. 25, 1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/67	
23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR JAN 3 1968	
		25b. REGISTRAR'S SIGNATURE Charles J. Geiger	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. If either, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia		b. COUNTY Manassas	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 58 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manassas		d. STREET ADDRESS 251 King George Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marion		First Carlton	Middle BARNES	4. DATE OF DEATH December 13	Month 1967	Doy 19	Year 67
S. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jul. 15, 1921	9. AGE (in years last birthday) 46 yrs	10. IF UNDER 1 YEAR Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USMC		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Eureka, North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leslie Norman Barnes				14. MOTHER'S MAIDEN NAME Eva Strother			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1942-1967		16. SOCIAL SECURITY NO 240 01 1458		17. INFORMANT Manassas		Address Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) due to Hepatic necrosis massive, with bleeding						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) due to (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Idiopathic thrombocytopenic purpura						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) Oct. 16, 1967, to Dec. 13, 1967, that we last saw the deceased alive on Dec. 13, 1967, and that death occurred at 855 AM, from causes and on the date stated above					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 16, 1967, to Dec. 13, 1967, that we last saw the deceased alive on Dec. 13, 1967, and that death occurred at 855 AM, from causes and on the date stated above							
22a. SIGNATURE Ross B. Moquin		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22b. DATE SIGNED Dec. 13, 1967	
22c. PHYSICIAN'S NAME (Type) Ross B. Moquin, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/15/67		23c. NAME OF CEMETERY OR CREMATORIAL Stonewall Memory Gardens		23d. LOCATION (City or Town) (County) (State) Manassas, Virginia	
24. FUNERAL DIRECTOR Falls Church Funeral Home 1102 West Broad Street, Falls Church, Virginia		ADDRESS		25a. RECD BY REGISTRAR DEC 18 1967		25b. REGISTRAR'S SIGNATURE Lionel Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17130

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE D. C.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c LENGTH OF STAY IN lb e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d STREET ADDRESS 620 Princeton Place, N. W.	
3 NAME OF DECEASED (Type or print) Elmore		First Loveing	Middle Barnett
4 DATE OF DEATH December 2 1967	Month Dec	Day 2	Year 1967
5. SEX male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/18/1886
9. AGE (In years from last birthday) 81 yrs	10. KIND OF BUSINESS OR INDUSTRY Butler	11 BIRTHPLACE (County & State, or foreign country) Massies Mill, Virginia	12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Barnett		14 MOTHER'S MAIDEN NAME Sylvia Barnett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 579-60-5899	
17. INFORMANT Wife - Loretta Barnett		18. ADDRESS 620 Princeton Pl W Wash, D. C.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 33 IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any. (b) Cerebral arteriosclerosis DUE TO DUE TO (c)		20. INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from November 20, 1967 , to December 2, 1967 , that (I) (we) last saw the deceased alive on November 28, 1967 , and that death occurred at 2 P.M. , from causes and on the date stated above.		20f. (City or town) Landover (County) P G Co (State) Md	
22a. SIGNATURE Myron Lenkin		M.D. <input type="checkbox"/> ATTENDING PHYS MED. DIRECTOR <input type="checkbox"/> STAFF PHYS	22b. DATE SIGNED December 2 1967
22c. PHYSICIAN'S NAME (Type) Myron Lenkin		22d. ADDRESS University Nursing Home Wheaton, Md	
23a. BURIAL, CREMATION, REMOVAL (If city) Burial		23b. DATE THEREOF 12/6/1967	23c. NAME OF CEMETERY OR CREMATORIAL Harmony MEM Cemetery
24. FUNERAL DIRECTOR William Spangler ADD 524 8th St N.E. Wash, D.C.		25a. LOCATION (City or Town) (County) (State) Landover P G Co Md	
		25b. REC'D BY REGISTRAR Charles Jussey	
		25c. REGISTRAR'S SIGNATURE Charles Jussey	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17131

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. If any event, within 24 hours after death, page 4 may be retained by the hospital or attending physician.

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 4 hrs 30 min	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d STREET ADDRESS 4261 Americana Drive	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECESSED (Type or print)	First Rutledge	Middle Birmingham	Last BARRY
S SEX Male	6. COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) New York City, N. Y.		9. AGE (In years lost birthday) 71 yrs	
13. FATHER'S NAME Benjamin Barry		14. MOTHER'S MAIDEN NAME Evelyn Birmingham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO 081-03-9166	
17 INFORMANT Terrace, Fairfax Address Virginia Mrs. Helen Stuber, 10117 Spring Lake		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Occlusive coronary arterio-clerotic disease INTERVAL BETWEEN ONSET AND DEATH 4-201	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), (c)		DUE TO (b) Pulmonary edema	
		DUE TO (c) _____	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDER, YING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
21. I certify that (I) (this hospital) attended the deceased from 8 December 1967 , to 8 December 1967 , that (I) (we) last saw the deceased alive on 8 December 1967 , and that death occurred about 1967 M, from causes and on the date stated above.		20f. (City or town) Washington (County) District of Columbia (State) DC	
22a. SIGNATURE Robert E. Bullock		22b. DATE SIGNED 9 Dec. 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/11/67	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery
24. FUNERAL DIRECTOR Noser Funeral Home		23d. LOCATION (City or Town) (County) (State) Woodlawn, Va.	
ADDRESS Washington, Virginia		25a. REC'D BY REGISTRAR J. H. Noser	25b. REGISTRAR'S SIGNATURE Charles Judge
DATE DEC 12 1967			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

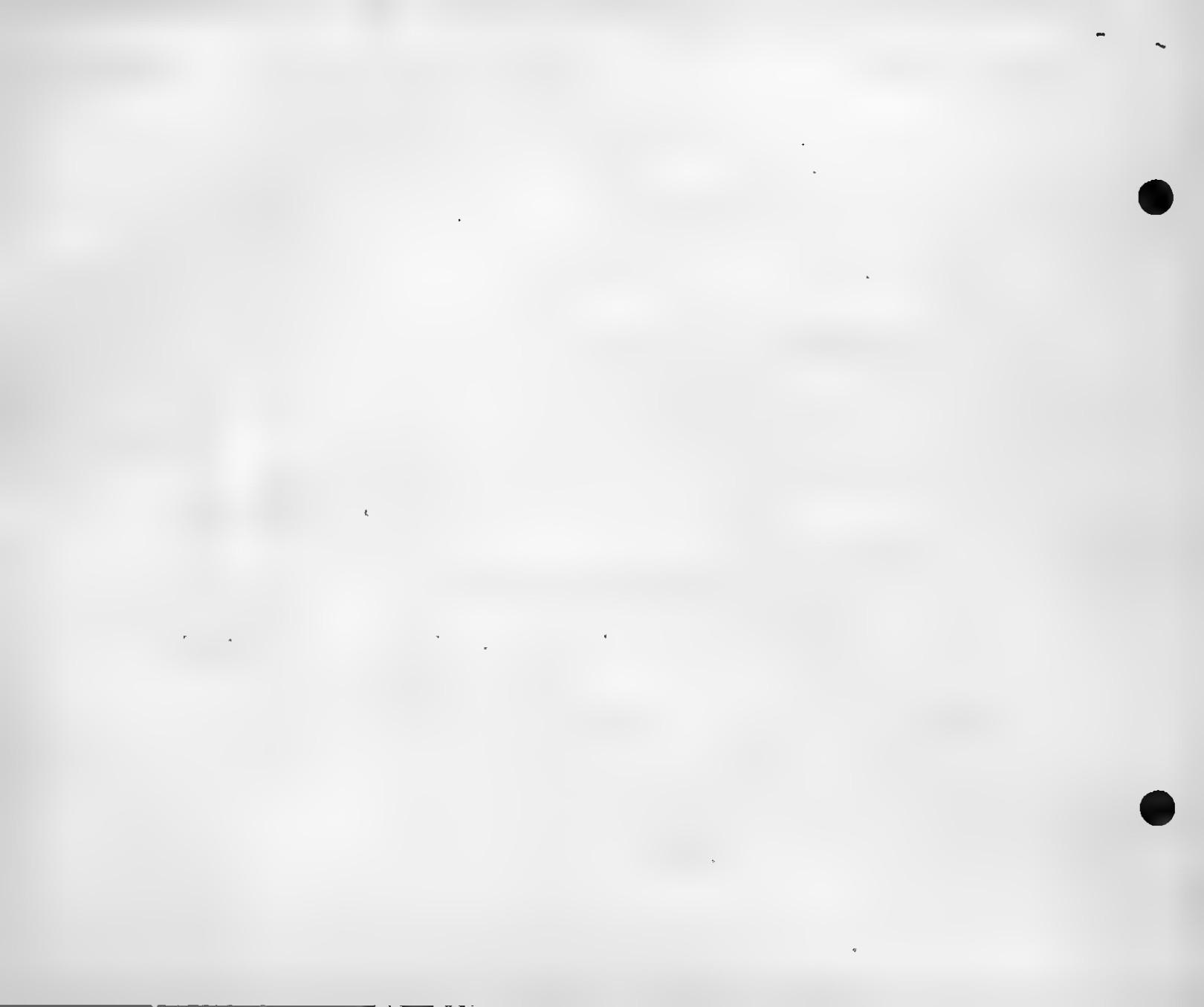
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item # Film # 539612 ph

CERTIFICATE OF DEATH

17136 17132

1. PLACE OF DEATH a. COUNTY MONTGOMERY			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN lb 7 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN			e. STREET ADDRESS 4500 WINDSOR LANE		
3. NAME OF DECEASED (Type or print) TRESSA		First M	Middle N	Last BEALL	4. DATE OF DEATH Dec 12 1967
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 5/4/07	10. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State or foreign country) Murray, Kentucky			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John C. Oliver			14. MOTHER'S M AIDEN NAME Edwina (Unknown)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 17. INFORMANT Husband Homer Beall		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Bronchopneumonia, bilateral severe			INTERVAL BETWEEN ONSET AND DEATH week		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4/1X			DUE TO (b) DUE TO (c)		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Meningocele, right fronto-parietal area, residual (Craniotomy 1963)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1967 , to Dec. 12, 1967 , that (I) (we) last saw the deceased alive on Dec. 11, 1967 , and that death occurred at M , from causes and on the date stated above.					
22a. SIGNATURE Philip H. Varner, M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED PHILIP H. VARNER					
22c. PHYSICIAN'S NAME (Type) PHILIP H. VARNER		22d. ADDRESS 10630 Georgia Ave, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-14-67		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY,		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE DEC 15 1967	
				25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey	



FOR STATE

HEALTH DEPT.

Page 3 of 3

PM3

Form 10

State Department

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Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5.

5 may be retained for your files.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5.

5 may be retained for your files.

17133

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17133

1 PLACE OF DEATH a COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived if institutional Residence before admission) a STATE Maryland b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Germantown	c LENGTH OF STAY IN Tb 11 Months	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Germantown	d STREET ADDRESS Box 2. Riffleford Rd.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 2. Riffleford Rd.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3 NAME OF DECEASED (Type or print)	First Audry	Middle Naomi	Last Beckwith	4 DATE OF DEATH December 4 1967
5 SEX Fe.	6 COLOR OR RACE Negrocl	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct 24 1940
9 AGE (In years last birthday) 27 yrs	10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	11 IF UNDER 24 HRS Hours 0 Min 0		

12 DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	13 FATHER'S NAME Woodward. Hobbs.	14 MOTHER'S MAIDEN NAME Anne-	15 CITIZEN OF WHAT COUNTRY USA.
--	---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Father. Box 2. Riffleford Rd Germantown.	Address
--	-------------------------	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Strangulation - DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 2 MIN --
---	---

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	--	---

20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of Item 18) Husband strangulated her.
20c TIME OF INJURY Month, Day, Year Hour am 10 pm 12/4 1967	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>
	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) Trailer.
	20f (City or Town) (County) (State) Rural Germantown Montgomery Md.

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
---	--

ACTUAL SIGNATURE John G. Ball	CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
22. DATE SIGNED Dec. 4, 1967	

23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF Dec. 9, 1967	23c NAME OF CEMETERY OR CREMATORIAL ADDRESS Asbury Cemetery Rockville, Md.	23d LOCATION (City or Town) (County) (State) Germantown Montg. Md.
24 FUNERAL DIRECTOR Robert L. Snodden	25a REC'D BY REGISTRAR DEC 8 1967	25b REGISTRAR'S SIGNATURE Charles George	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
<i>Montgomery County Maryland</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>11/26/67 - 12/6/67</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Frank</i>	Middle <i>J.</i>	Last <i>Begley</i>
4. DATE OF DEATH	Month <i>12</i>	Day <i>6</i>	Year <i>1967</i>
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>4/7/88</i>		9. AGE (In years last birthday) <i>79 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pet Business</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pet. Business</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James Begley</i>		14. MOTHER'S MAIDEN NAME <i>Callie Begley</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>226-16-2139</i>	
17. INFORMANT <i>A Earle Matlock-Son-in-law-708 S. Stone-</i>		Street, Ave. Rock	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Aspiration</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Caudiorascular Collapse / he</i>	
DUE TO <i>Aspiration</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Gastric Contents 2 hours</i>			
DUE TO <i>Cerebral arterial occlusion</i>		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <i>12-6-67</i>
20f. (City or town) <i>12-6-67</i>		(County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <i>11/26</i> , 1967 to <i>12-6</i> , 1967, that (1) (we) last saw the deceased alive on <i>12-6</i> 1967, and that death occurred at <i>6:30</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>M. W. Shapiro</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>12-6-67</i>
22c. PHYSICIAN'S NAME (Type) <i>M. W. Shapiro</i>		22d. ADDRESS <i>8107 Eastern Ave., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/9/67</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Maggie Smith Cemetery</i>		23d. LOCATION (City or Town) <i>Jonesville, Va.</i>	
23e. (County) (State)			
24. FUNERAL DIRECTOR <i>Tyson Wheeler F. H.</i>		25a. REC'D BY REGISTRAR <i>1331 Rockville Pike</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
		DATE DEC 8 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN b 38 hours		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Washington D.C.		b. COUNTY D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Elizabeth		First	Middle	Last	4 DATE OF DEATH December 11, 1967	Month	Day	Year	
S SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH 11-3-90	9. AGE (in years last birthday) 77 yrs	10 UNDER 1 YEAR Months 0	11 UNDER 24 HRS Days 0	Hours 0	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Home		11 BIRTHPLACE (County & State, or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? America			
13. FATHER'S NAME William Ziegler		14. MOTHER'S MAIDEN NAME Katherine Oberglock							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-50-6417		17. INFORMANT Patinet's chart		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4221		DUE TO (b)		RENAL FAILURE - UREMIA		INTERVAL BETWEEN ONSET AND DEATH -3 DAYS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Arteriosclerotic cardiovascular disease		DUE TO (c)		CONGESTIVE HEART FAILURE		4 months			
				ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		2 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) RHEUMATOID ARTHRITIS - DEFORMING		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) New York	(County) N.Y.	(State) N.Y.			
21. I certify that (I) (this hospital) attended the deceased from Nov. 19, 1966 to DEC 14, 1967 , that (I) (we) last saw the deceased alive on DEC 13, 1967 , and that death occurred at 2357 1/2 M. from causes and on the date stated above.									
22a. SIGNATURE <i>Robert L. Krichmar</i>		MD ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 12/14/67				
22c. PHYSICIAN'S NAME (Type) Robert L. Krichmar		22d. ADDRESS 1733 Alaska Avenue N.W. Washington, D.C. 20009							
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-19-67 Woodlawn Cemetery		23b. DATE THEREOF 12-19-67	23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery	23d. LOCATION (City or Town) New York N.Y.			(County) N.Y.	(State) N.Y.	
24. FUNERAL DIRECTOR W.H. Glazerman & Son		ADDRESS 5733 1/2 Ave	25a. REC'D BY REGISTRAR DECEMBER 21, 1967			25b. REGISTRAR'S SIGNATURE <i>Charles J. Glazerman</i>			



Items 18-21 Film 396 MARYLAND STATE DEPARTMENT OF HEALTH
1-15-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

7140

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17136

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if inst tut on, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) In route		c. LENGTH OF STAY IN lb D.O.A.	b. COUNTY Howard
d. NAME OF HOSPITAL OR INST TUTION (If not in hospital, give street address) Montgomery General		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville	
3. NAME OF DECEASED (Type or print) Hamilton		First Lewis	Middle Bennett
4. DATE OF DEATH 12	Month 12	Doy 24	Year 1967
5. SEX Male	6. COLOR OR RACE Negro	7. MARR ED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 8-5-30
9. AGE (in years last birthday) 37 yrs		10. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Bennett		14. MOTHER'S MAIDEN NAME Oxie Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 17. INFORMANT Florence Bennett, Rte. 32, Simpsonville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation due to aspiration of blood		Address	
DUE TO 171. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) from ruptured esophageal varices.		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Severe fatty infiltration of liver			
19. WAS AUTOPSY PERFORMED? YES		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20a. TIME OF INJURY Month, Day, Year Hour o.m. 4:15 pm 12-24 1967		20b. DESCR BE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Deceased vomited and aspirated vomitus.	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. (City or town) Simpsonville		(County) (State) Howard Md.	
21. I certify that I took charge of the remains descr bed above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Leap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or county) <i>Arlington, Virginia</i>	
EXAMINER'S NAME (Type) BELDEN R. LEAP M.D.		22. DATE SIGNED DEC. 24 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/67	
23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City or Town) Baltimore	
24. FUNERAL DIRECTOR Robert L. Snowden		ADDRESS Rockville, Maryland	
25a. REC'D BY REGISTRAR JAN 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If 24 hr delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

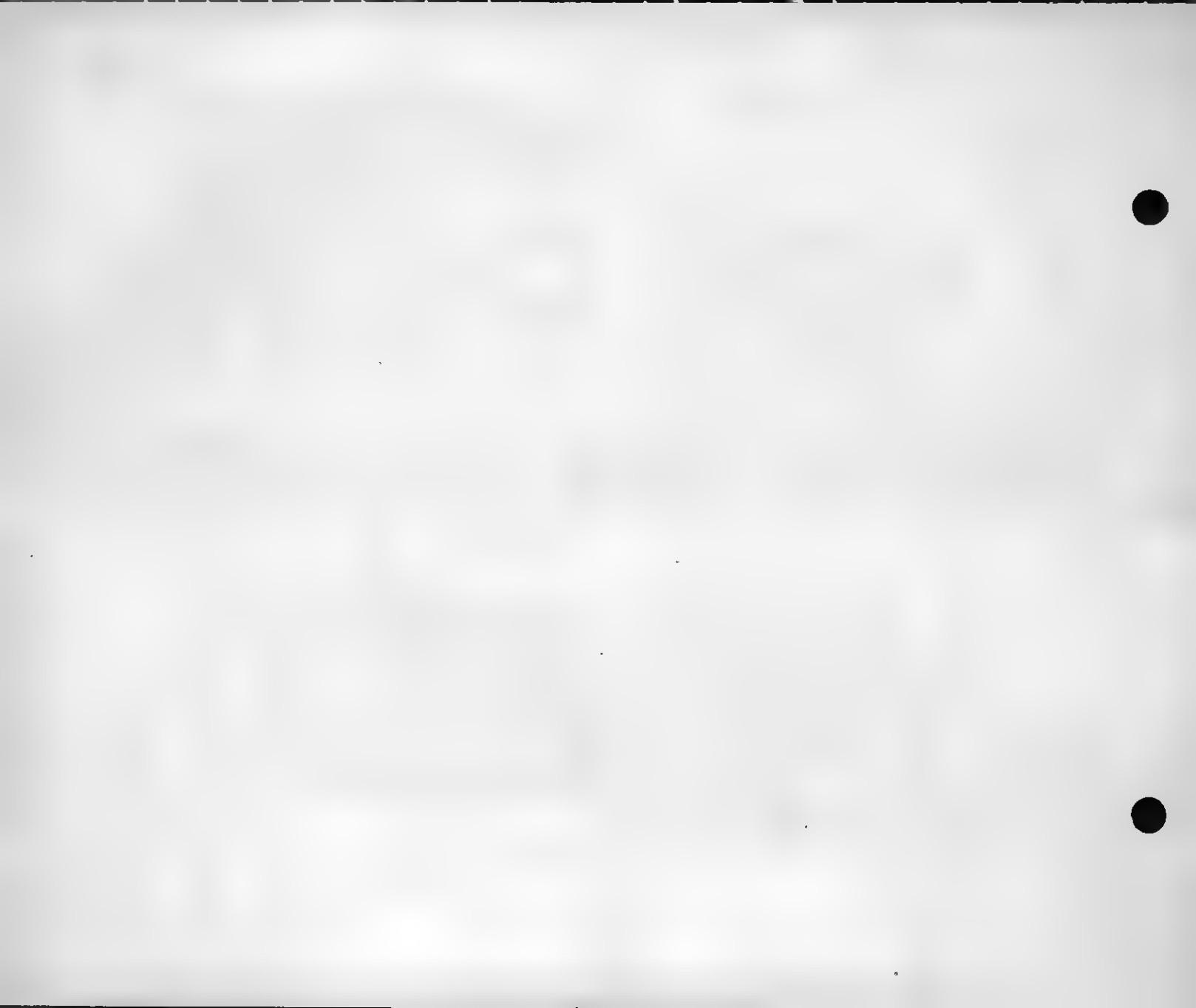
CERTIFICATE OF DEATH

17137

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and g-vb nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SANITARIUM + HOSPITAL				d. STREET ADDRESS 415 E. UNIVERSITY BLVD.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First HAROLD Middle JESSE Last BERNEY		4. DATE OF DEATH Month DECEMBER Day 19 Year 1967							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6/9/98		9. AGE (In years lost birthday) 69 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMMERCIAL ARTIST		10b. KIND OF BUSINESS OR INDUSTRY PATRICK SIGNS Co		11. BIRTHPLACE (County & State, or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? AMERICAN			
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Calcific Aortic Stenosis						Years			
DUE TO (b) Severe Pulmonary Embolism									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Pulmonary Embolism									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from 10-9-1967 , to 12-19-1967 , that (I) (we) last saw the deceased alive on 10-19-1967 , and that death occurred at 3:05 PM , from causes and on the date stated above.									
22a. SIGNATURE Samuel A. Hillman		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				DATE SIGNED 12/19/67			
22c. PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN, MD		22d. ADDRESS 8829 FLOWER AVE SILVER SPRING, MD 20901							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 22, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		ADDRESS		25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Decided with Dr. Bellon Beagle 1/20/67

CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN lb 5 years. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11919 Old Columbia Pike						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 11919 Old Columbia Pike e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED First HENRY Middle L Last Berry (Type or print)						4. DATE OF DEATH Month December Day 19 Year 1967							
5. SEX Male 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 1991		9. AGE (in years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0					
10. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired conductor				10b. KIND OF BUSINESS OR INDUSTRY D. C. Transit				11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wesley Berry						14. MOTHER'S MAIDEN NAME Dora Collins							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 220-46-5611				17. INFORMANT William Marlowe Address 4416 Dundas Street Theater, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A.S.C.V.D. DUE TO (b) Coronary Atherosclerosis INTERVAL BETWEEN DEATH AND DEATH 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Generalized Arterosclerosis DUE TO (c) Generalized Arterosclerosis 15 yrs.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis + Emphysema 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20d. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 0 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) Laurel (County) Md. (State)	
				21. I certify that (I) (this hospital) attended the deceased from 11/10 , 1967 to 12/14 , 1967 that (I) (we) last saw the deceased alive on 11/10 , 1967, and that death occurred at 6:00 PM , from causes and on the date stated above.		22a. SIGNATURE J M Warren		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Laurel Md			
22c. PHYSICIAN'S NAME (Type) J M Warren				22d. ADDRESS Prince Georges Co. Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF Dec. 22, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Mausoleum		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.							
24. FUNERAL DIRECTOR John J. Murphy, Inc.		ADDRESS 81-34 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE Franklin Judge							



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

PAGE 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

17138

CERTIFICATE OF DEATH

1		1143		2		
1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
Montgomery				a. STATE	b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MONTGOMERY		MD	MONTGOMERY	
Wheaton, Md.		2 yrs. +		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		University Nursing Home		SILVER SPRING		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	
MARY				Bittner	Month Day Year	
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	
F		CAUS	<input checked="" type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	10-14-90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.		
Housewife		in home		77 yrs.	Months Days Hours Min.	
13. FATHER'S NAME		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
E. Shirley Clark		Dubois, Penna.		USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address		
No		573-47-11765		Katherine Bittner, 1401 Blair Mill Rd., Silver Spring, MD 20910		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Pulmonary Edema				
-341 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Viral Pneumonia			
		DUE TO (c)	Congestive Heart Failure (Atherosclerosis)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18 days 2 yrs				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Cerebral Vascular accidents - Senility		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
19						
21. I certify that (I) (this hospital) attended the deceased from 9-1, 1967, to Dec 29, 1967, that (II) (we) last saw the deceased alive on Dec 29, 1967, and that death occurred at 1401 Blair Mill Rd., Silver Spring, MD, from the causes and on the date stated above.						
22a. SIGNATURE		22b. DATE SIGNED				
Philip E. Jones, Philip E. Jones MD		M.D. PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	12/29/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 800 Parkview Dr., Silver Spring, MD 20902				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Jan 2, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery	23d. LOCATION (City, town or county) Washington, D.C.	(State)	
24. FUNERAL DIRECTOR		ADDRESS Warner E. Humphrey Inc. 8434 Georgia Ave. S.S.		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge	
John Porter				DATE JAN 8 1968		
VR A15 (4) 15M 4-64						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>151</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Marcella</i>	Middle <i>P.</i>	4. DATE OF DEATH Month <i>December</i> Day <i>10</i> Year <i>1967</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-14-06</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Piano Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	9. AGE (In years last birthday) <i>62 yrs</i>
13. FATHER'S NAME <i>Bruce Palmer</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Nebraska</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
16. SOCIAL SECURITY NO <i>no</i>		17. INFORMANT <i>Mr Wendell Blanchard - absent</i>	Address <i>(House)</i>
18. CAUSE OF DEATH (Enter on y one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) <i>Carcinomatosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. <i>110X</i> (b) <i>Adenocarcinoma, breast</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(City or town) <i>(County)</i> <i>(State)</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1967</i> to <i>Dec 10 1967</i> , that (II) (we) last saw the deceased alive on <i>Dec 10 1967</i> , and that death occurred at <i>Bethesda</i> , M.D. from causes and on the date stated above			
22a. SIGNATURE <i>William H. Kille</i>		22b. DATE SIGNED <i>10-11-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dr. William H. Kille</i>		22d. ADDRESS <i>8218 Wisc. Ave. Bethesda, Md.</i>	
23a. BURIAL, CREMATION REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>12/12/67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR HILL CREM.</i>		23d. LOCATION (City or Town) <i>SUITLAND, MD.</i>	
24. FUNERAL DIRECTOR <i>Joseph Tamburinone Washington DC</i>		25a. ADDRESS <i>1101 1/2 L Street N.W. Washington, D.C.</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
		DATE <i>DEC 15 1967</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN Month Day Year	2b. HOUR	
		MARK	A.	BLUME	DEATH ESTI DEATH MATED <input checked="" type="checkbox"/> December 18	UNK M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR	
male	white	July 11, 1944	23 yrs.		April 13, 1968	UNKM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH		
		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Montgomery		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda				STUDENT			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington, D.C.		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 4101 Cathedral Ave. N.W.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last	
		Jack	Paul	Blume	Ethel	Nelson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		ADDRESS WASH. D.C.	
No		217-44-9773		MR. JACK PAUL BLUME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Drowning					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day Year HOUR A.M. UNK P.M. 12/18 1967		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) apparently drowned			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.) water		21f. LOCATION Street or R.F.D. No		City or Town Bethesda, Montgomery, Md.	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Werner U. Spitz, M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					22b. DATE SIGNED 4/17/68
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 4/17/68		23c. NAME OF CEMETERY OR CREMATORIAL Greenmount		23d. LOCATION (City or Town) Baltimore, Maryland	
24. FUNERAL DIRECTOR		ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland		25a. REC'D BY REGISTRAR APR 18 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Juge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17141

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgefield Park, New Jersey		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resmar Hospital		e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Resmar Hospital, Ridgefield Park, N.J.	
3. NAME OF DECEASED (Type or print) FEMALE		First MAY	Middle A.
4. DATE OF DEATH 12 25 1967		Last Boiseau	Month Day Year
5. SEX FEMALE		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED
8. DATE OF BIRTH Jan. 1, 1883		9. AGE (In years last birthday) 83 84	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) WASHINGTON DC USA
13. FATHER'S NAME PATRICK Dougherty		14. MOTHER'S MAIDEN NAME BRIDGET HAMILTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-34-5227	
17. INFORMANT E. Edward Dougherty Hyattsville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
		20f. (City or town) Hyattsville	(County) Maryland
		(State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from Sept 19, 1967 to Dec 25, 1967 , that (I) (we) last saw the deceased alive on Dec 25, 1967 , and that death occurred at 4039 Shorefield Road, Hyattsville, Md. from causes and on the date stated above.			
22a. SIGNATURE M. Lenkin		M.D. ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
22b. PHYSICIAN'S NAME (Type) Maryan L. Lenkin		22d. ADDRESS 2309 Shorefield Road, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 28, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cemetery
23d. LOCATION (City or Town) Hyattsville, Md.		(County) Maryland	
		(State) Maryland	
24. FUNERAL DIRECTOR Thomas J. Murphy, Inc.		25a. ADDRESS 7100 Georgia Ave., Silver Spring, Md.	25b. REC'D BY REGISTRAR DEC 28 1967
		DATE 12-25-67	
		REG STRR'S SIGNATURE John J. Murphy	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Then please remove carbon paper, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH							17142					
1 PLACE OF DEATH a. COUNTY Montgomery				MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN lb			b. COUNTY Montgomery					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2226 Washington Avenue							e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
3 NAME OF DECEASED (Type or print) ROSE				First	Middle	Last	4 DATE OF DEATH 12-26-67	Month	Day	Year		
5. SEX F	6. COLOR OR RACE W	7 MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH 3-3-95			9. AGE (In years less birthday) 72 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours	Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b KIND OF BUSINESS OR INDUSTRY			11 BIRTHPLACE (County & State, or foreign country) Poland				12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gershon Gottlieb				14. MOTHER'S MAIDEN NAME Sarah								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO			17. INFORMANT Louis Bojan(SON) 7005 Loch Lomond Dr.				Address Bethesda, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				<i>Valvular insufficiency</i>				INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)				<i>Arteriosclerotic arterioplasia</i>				2 year				
DUE TO (c)				<i>Heart disease</i>								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Hyattsville		(County) Hyattsville		(State) Maryland
21. I certify that (I) (this hospital) attended the deceased from 11/6/67 , 19____, to 12/4/67 , 19____, that (I) (we) last saw the deceased alive on 12/4/67 , 19____, and that death occurred at 3:30 P.M. , from causes and on the date stated above												
22a. SIGNATURE <i>Bernard J. Walsh</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 12/30/67				
22c. PHYSICIAN'S NAME (Type) BERNARD J. WALSH				22d. ADDRESS <i>1800 E. Eye St. N.W.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-28-67		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Lebanon Cemetery			23d. LOCATION (City or Town) Hyattsville, Maryland		(County) Hyattsville		(State) Maryland	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		ADDRESS 3501 14th St. N. W. Washington, DC 20010		25a. REC'D. BY REGISTRAR DEC 29 1967			25b. REGISTRAR'S SIGNATURE <i>John Danzansky</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17143

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN lb <u>2 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN ECHO</u>		d. STREET ADDRESS <u>5900 OXFORD ROAD</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>LAWRENCE OLIVER BOLTON, SR.</u>		First	Middle	Last	4. DATE OF DEATH <u>DEC - 4 1967</u>	Month	Day	Year
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/6/1894</u>	9. AGE (In years last birthday) <u>73 yrs</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. CTS OFFICE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND, Gaithersburg U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Lewis Edward Bolton</u>		14. MOTHER'S MAIDEN NAME <u>ODEN, IDA L.</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>678-32-4331</u>		17. INFORMANT <u>RUTH BOLTON - WIFE - SAME</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1621</u> DUE TO <u>Respiratory, pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>								
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO stating the underlying cause (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>p.m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , to <u>1967</u> , that (I) (we) last saw the deceased alive on <u>3 Dec 1967</u> , and that death occurred at <u>SICK</u> , from causes and on the date stated above.								
22a. SIGNATURE <u>Dr. J. D. Pumphrey</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4 Dec 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>J. D. Pumphrey</u>		22d. ADDRESS <u>4417 University</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-6-67</u>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>		
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED WITH MEDICAL EXAMINER, B&B

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MARYLAND		b. COUNTY		MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b SILVER SPRING Md 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SILVER SPRING		d. STREET ADDRESS		9000 KIMES St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>DIED AT HOME</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min		
FEMALE		WHITE		APPROX 1887	80 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife				RUSSIA		U.S.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
JACOB GROSMAN		UNKNOWN									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
		218-52-9096		SANFORD BOMSTEIN		9000 KIMES 81. SIC Spc. Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		ACUTE MYOCARDIAL INFARCTION				IMMEDIATE					
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		HYPERTENSIVE ARTERIOSCLEROTIC							
		DUE TO		CARDIOVASCULAR DISEASE							
		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c TIME OF INJURY Hour a. m. p. m.		Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)		
19											
21. I certify that (I) (this hospital) attended the deceased from _____						Jan 1952 to Dec 1967					
saw the deceased alive on 12-19 1967						, and that death occurred at 73 M, from the causes and on the date stated above.					
22a. SIGNATURE		M.D.		ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED				
Bernard A. Fitzgerald							12-19-67				
22c. PHYSICIAN'S NAME (Type)		ADDRESS		22d. ADDRESS							
BERNARD A. FITZGERALD		217 UNION BLVD. SILVER SPRING MD		217 UNION BLVD. SILVER SPRING MD							
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county)		(State)			
CREMATION		12/22/67		MT. LEBANON CEM.		HYATTSVILLE, MD.					
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Dealey Funeral Home 4217-9 E. ST. STE. 100				DEC 26 1967		M. Miles Judge					
VR A15 (4) ISM 9/59											



FOR STATE
HEALTH DEPT.

1
M
PMS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) d. STATE	
<i>Montgomery</i> <i>Maryland</i>		<i>Maryland</i> <i>b. COUNTY</i> <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Bethesda</i> <i>D.O.C.</i> <i>Suburban</i>		<i>Takoma Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)		First	Middle
<i>Andrew Joseph</i>		<i>Beagg</i>	<i>Beagg</i>
4 DATE OF DEATH		Month	Day
		<i>12 - 4</i>	<i>1967</i>
5 SEX	6 COLOR OR RACE	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH DIVORCED <input type="checkbox"/>
<i>M</i>	<i>W</i>	<i>NEVER MARRIED</i> <input type="checkbox"/>	<i>7-3-30</i>
9 AGE (in years (on birthday) yrs.		10 UNDER 1 YEAR Months	11 IF UNDER 24 HRS Days
<i>37</i>			
10 DO USA. OCCUPATION (Give kind of work done during most of working life, even if retired)		11 BIRTHPLACE (State or foreign country)	
<i>Window Washer</i>		<i>New Jersey</i>	
12. CITIZEN OF WHAT COUNTRY?		U. S.	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S Maiden Name <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOC. SEC. SECURITY NO <i>228-32-6674 Mamie M. Bragg</i>	
17. INFORMANT <i>wife</i>		Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>Scat</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost.</i>		DUE TO (b) <i>Fraction of Skull - due to fall from Scaffold</i> DUE TO (c) <i>Sudden.</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20d. EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Fall off scaffold when climbing Windows</i>	
20c. TIME OF INJURY Month, Day, Year <i>8:45 a.m. 12-4 1967</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <i>effectively</i>
		20f. (City or town) <i>Bethesda Mont. Md.</i>	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <i>Bethesda, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>12-12-67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS	
		25a. REC'D BY REGISTRAR <i>DEC 18 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>James J. Geary</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17148

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10a FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with a 72 hours after death.

1 PLACE OF DEATH a. COUNTY MONTGOMERY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. LENGTH OF STAY IN 1b 1 yr. 9 mos. 23 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORFOLK		d. STREET ADDRESS 6913 Fallister Rd.	
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BETHESDA - SILVER SPRING Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Roland Mo Brainard		4. DATE OF DEATH Month 12 Day 28 Year 1967	
S SEX M	6. COLOR OR RACE C	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 5-17-86		9. AGE (In years last birthday) 81 yrs	
10a. JSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) VICE ADMIRAL - USNavy - RET.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) INNAPOLIS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FREDERICK BRAINARD		14. MOTHER'S MAIDEN NAME Mary Ann Munroe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 264 52 9192	
17. INFORMANT PATIENT'S CHART # 1		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) ganglionic atrophy			
DUE TO (c) multiple sclerosis		YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Grove
20f. (City or town) Grove (County) Montgomery (State) M.D.			
21. I certify that (I) (this hospital) attended the deceased from Grove , 1966, to 12/28 , 1967, that (I) last saw the deceased alive on 12/28 1967 , and that death occurred at 2:15 PM , from causes and on the date stated above.			
22a. SIGNATURE G. Lennard Gow		22b. DATE SIGNED 12/28/67	
22c. PHYSICIAN'S NAME (Type) G. Lennard Gow		22d. ADDRESS 3641 Colesville Rd, Silver Spring, Md.	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-2-1968	23c. NAME OF CEMETERY OR CREMATORIAL U.S.N. ACADEMY
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis Md.		ADDRESS	25a. LOCATION (City or Town) Annapolis (County) A.H. (State) M.D.
		25b. REC'D. BY REGISTRAR JAR DATE 3 1968	25c. REGISTRAR'S SIGNATURE Charles J. George



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17147

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. LENGTH OF STAY IN 1b <i>3 months</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Randolph Hills Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
3. NAME OF DECEASED (Type or print) GERTRUDE		First BRAUNER	Middle Last 4. DATE OF DEATH Dec 29 1967
5. SEX Female		6. COLOR OR RACE Cauc	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED 8. DATE OF BIRTH 3-18-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker		10b. KIND OF BUSINESS OR INDUSTRY Amer. Red Cross	9. AGE (in years last birthday) 75 yrs
13. FATHER'S NAME Richard Brauner		11. BIRTHPLACE (County & State, or foreign country) District of Col.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 579-44-5279A	17. INFORMANT Evelyn Woodward - Neice
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5810		Address Caroline Hanke	
IMMEDIATE CAUSE (a) Cirrhosis of the Liver		INTERVAL BETWEEN ONSET AND DEATH Under	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO	
		DUE TO	
		(c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 10-9 1967 , to 12-29 1967 , that (I) (we) last saw the deceased alive on 12-19 1967 and that death occurred at 6 A.M. from causes and on the date stated above		20f. (City or town) 12-29-67	(County) 12-29-67
22a. SIGNATURE <i>B.C. Bendlar MD</i>		22b. DATE SIGNED 12-29-67	
22c. PHYSICIAN'S NAME (Type) B. C. Bendlar MD		22d. ADDRESS 10820 Georgia Ave, S. Soks, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12/31/67	23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory
24. FUNERAL DIRECTOR Lee F.H., 300 4th St NE, Wash., D.C.		ADDRESS	25a. REC'D BY REGISTRAR JAN 2 1968
			25b. REGISTRAR'S SIGNATURE <i>Judy</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-troupe permit. Then please remove carbon papers. Please sign and date page 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY MONTGOMERY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE WASH. D.C. b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c LENGTH OF STAY IN 1b 37 MONTHS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WHEATON NURSING HOME		e STREET ADDRESS 4411 17TH ST. N.W.	
3 NAME OF DECEASED (Type or print) MARY		First C. Middle BREEN	4 DATE OF DEATH Month 12 Day 21 Year 1967
S SEX F.	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH OCT. 8-1872
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Retired-TEACHER		10b KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years lost birthday) 95 yrs
13. FATHER'S NAME MICHAEL BREEN		14. MOTHER'S MAIDEN NAME KATHERINE O'BRIAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO 577-30-5280-#	17. INFORMANT Robert J. Beiler-3024 Oliver St. NW.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease, Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -
20f. (City or town) (County) - (State) -			
21. I certify that (I) (this hospital) attended the deceased from Oct. 21, 1967 to Dec. 21, 1967 , that (I) (we) last saw the deceased alive on Oct. 21, 1967 , and that death occurred at 9:30 P.M. from causes and on the date stated above			
22a. SIGNATURE Bertram F. Schaefer		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Dr. Bertram F. Schaefer		22d. ADDRESS 1780 Mass Ave. N.W. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Olivet Cemetery
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		5130 Wisconsin Ave. N.W. Wash. D.C.	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
			25a. REC'D BY REGISTRAR DATE DEC 28 1967
			25b. REGISTRAR'S SIGNATURE Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE									
<i>Montgomery</i> MARYLAND				Md									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
<i>Bethesda</i>		<i>7 days</i>		<i>Bethesda</i>		<i>Bethesda</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<i>Hopkins</i>				<i>10300 West Lake Dr</i>									
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH	Month	Day	Year				
<i>Edward</i>				<i>Brennan</i>		<i>Dec</i>	<i>24</i>	<i>1967</i>					
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	B. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS					
<i>M</i>	<i>W</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>9-22-1897</i>		<i>70 yrs</i>	Months	Days	Hours				
10a. USL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)					
<i>Retired</i>								<i>MADISON, Wisc.</i>					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
<i>Thomas Brennan</i>				<i>KATHRYN</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address					
								<i>(WIFE) GERTRUDE BRENNAN Same as #2</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY													
IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>													
4200													
DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerotic Heart Disease</i> 5 yrs													
stating the underlying cause (c) <i>Generalized arterosclerosis</i> 20 yrs													
DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19													
21. I certify that (I) (this hospital) attended the deceased from <i>10-7</i> , 19 <i>66</i> , to <i>12-24</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>12-24</i> 19 <i>67</i> and that death occurred at <i>981 M</i> , fram causes and an the date stated above.													
22a. SIGNATURE <i>Ronald W. Barr</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED <i>12-24-67</i>					
22c. PHYSICIAN'S NAME (Type) <i>Ronald W. Barr</i>				22d. ADDRESS <i>10401 Old Georgetown Rd, Bethesda, MD</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-28-67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cem.</i>				23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>					
24. FUNERAL DIRECTOR <i>James E. Dugot - Dugot Funeral Home - Wash. D.C.</i>		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Carley Judge</i>					
						DATE JAN 2 1968							

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

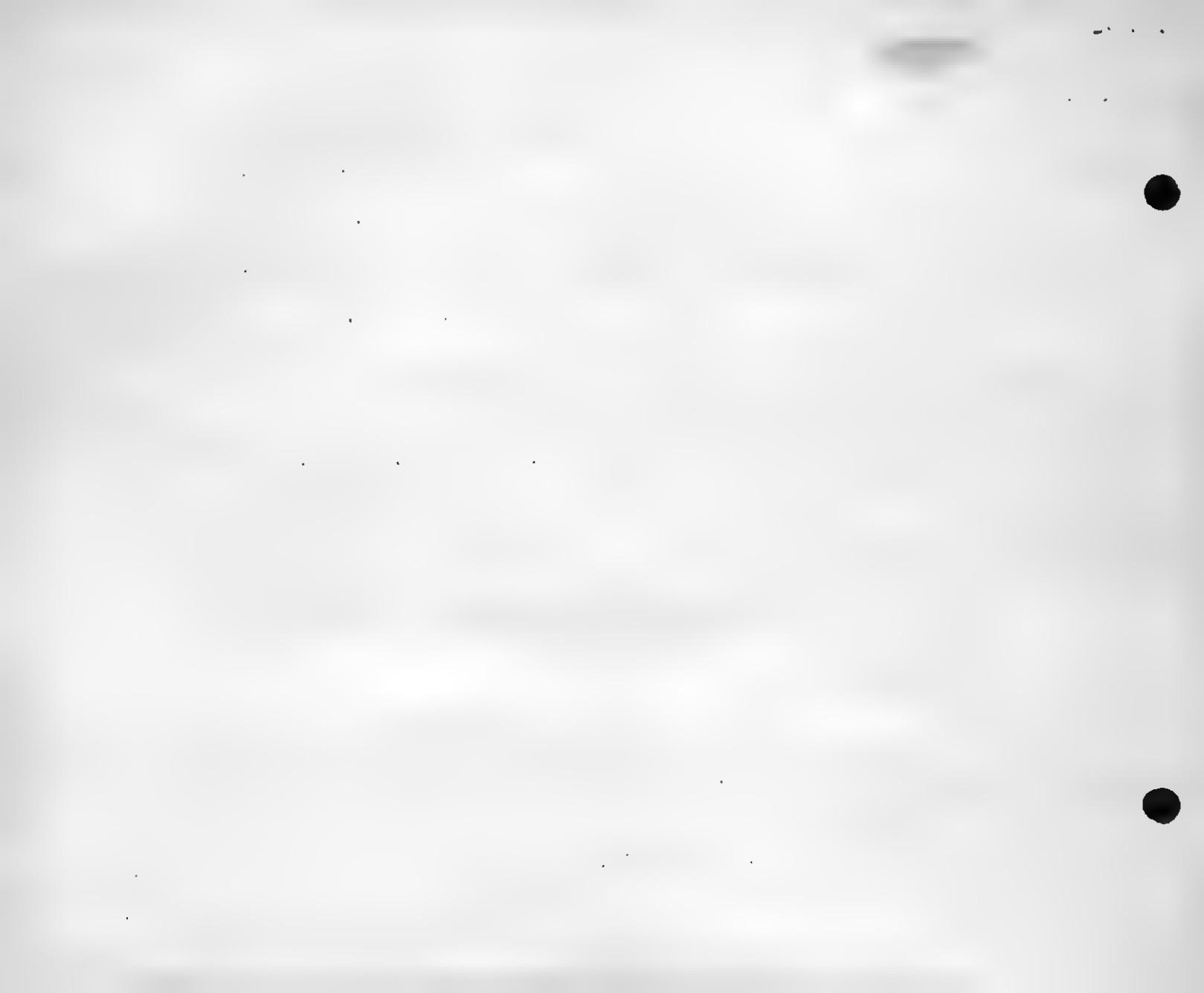
17150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in page 3, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS MEMQ 777A		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Christine Marie		First	Middle	Lost	4. DATE OF DEATH December 9 1967	Month	Doy	Year
S. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1967	9. AGE (In years lost birthday) yrs 1	FUNDER 1 YEAR Months 1	IF UNDER 24 HRS Days Hours Min.
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Patuxent River, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Wiley Phillip Brewer				14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO N/A		17. INFORMANT Mr. Wiley P. Brewer, MEMQ 777A Patuxent/		Address River, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningomyelocele INTERVAL BETWEEN ONSET AND DEATH 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c) DUE TO DUE TO DUE TO lost								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
MEDICAL CERTIFICATION	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
	20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (s) (this hospital) attended the deceased from Dec. 8, 1967 , to Dec. 9, 1967 , that (s) (we) last saw the deceased alive on Dec. 9, 1967 , and that death occurred at 1245 M , from causes and on the date stated above.								
22a. SIGNATURE <i>Jerry J. Tomasovic</i>		M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED Dec. 12, 1967		
22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-14-67	23c. NAME OF CEMETERY OR CREMATORIAL HOME Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS 7557 Wisconsin Ave., Bethesda, Md.				25a. REC'D BY REGISTRAR DATE DEC 15 1967		25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <i>District of Columbia</i> COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16 <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <i>5249-43rd St. N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburbane</i>						d. DATE OF DEATH <i>Tec. 14 1967</i>					
3. NAME OF DECEASED (Type or print)		First <i>Lillian</i>	Middle <i>E.</i>	Last <i>Broches</i>					Month <i>Tec.</i>	Doy <i>14</i>	Year <i>1967</i>
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 16 1895</i>	9. AGE (In years last birthday) <i>72 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home & Ch.</i>		11. BIRTHPLACE (County & State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Ritter</i>						14. MOTHER'S MAIDEN NAME <i>Dora English</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>—</i>						16. SOCIAL SECURITY NO <i>579-18-5921</i>		17. INFORMANT <i>Ralph Brooks Silverman</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>331X</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Hypertension</i>						DUE TO (b) <i>HT</i> (c) <i>Cerebral Vascular Accident</i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month Day Year Hour a.m. p.m. <i>19</i>			20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>12/14/67</i> , 1967, that (I) (we) last saw the deceased alive on <i>12/14/67</i> , 1967, and that death occurred at <i>9:30 AM</i> , from causes and on the date stated above											
22a. SIGNATURE <i>Lillian Broches</i>						22b. ADDRESS <i>1627 Clarendon Place N.W.</i>					
22c. PHYSICIAN'S NAME (Type) <i>A. S. Brennan Jr.</i>						22d. ADDRESS <i>Oberry Clarendon</i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>12-18-1967</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>			23d. LOCATION (City or Town) <i>Colmar Manor, Maryland</i>		
24. FUNERAL DIRECTOR <i>Lee Funeral Home-300 14th St. N.E. Wash.D.C.</i>						25a. REC'D BY REGISTRAR <i>Charles Judge</i>					
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						DATE <i>DEC 21 1967</i>					



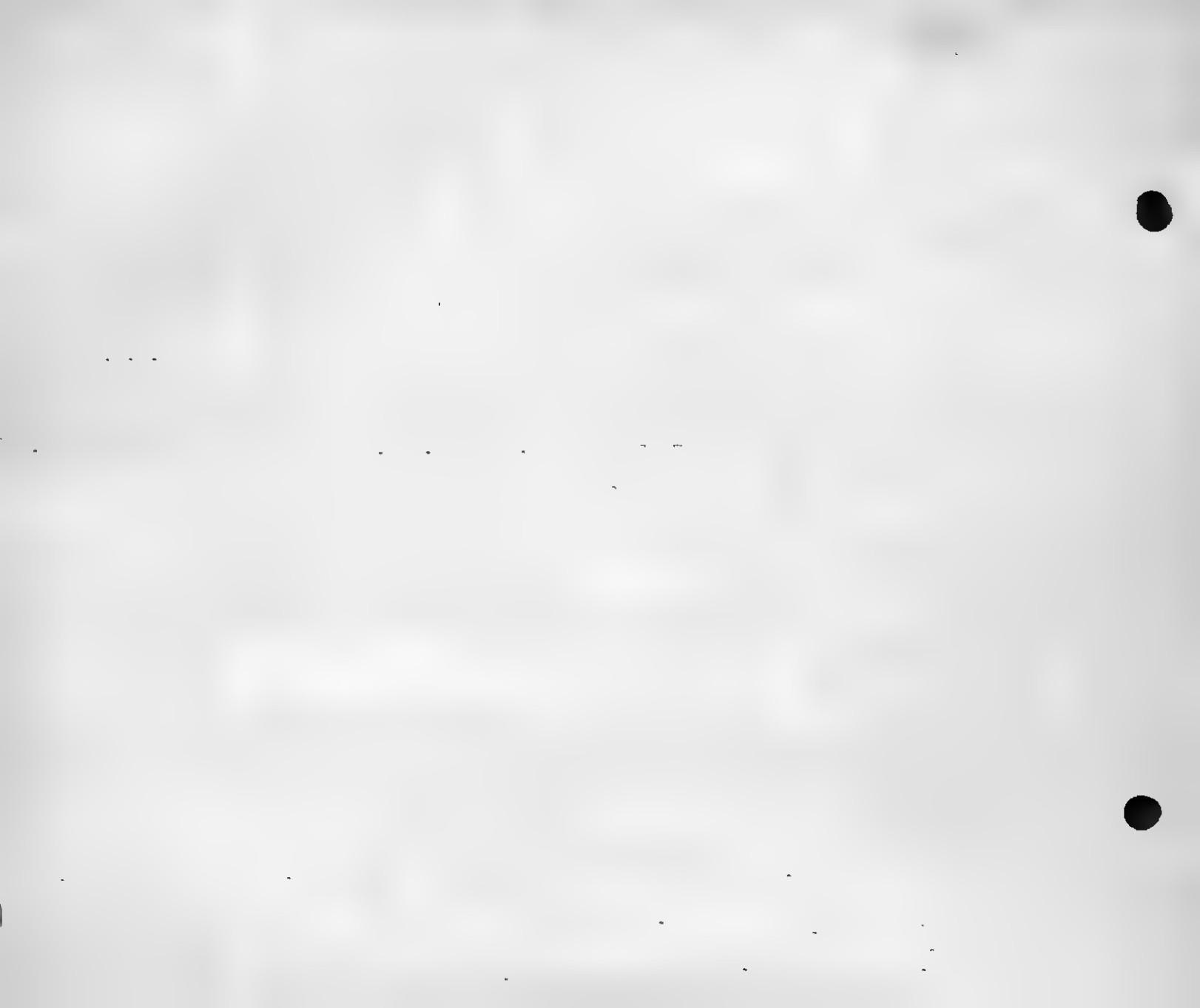
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7156

17152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 10715 Meadow Hill Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10715 Meadow Hill Road		d. STREET ADDRESS 10715 Meadow Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CHESTER John		First	Middle	Last	4. DATE OF DEATH BROOK'S	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH January 31, 1907	9. AGE (In years lost birthday) yrs. 60	10. IF UNDER 1 YEAR Months 50715 Meadow Hill Rd.	11. IF UNDER 24 HRS Days Silver Spring, Md.	Hours 12 CITIZEN OF WHAT COUNTRY?	Min. U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Kentucky				
13. FATHER'S NAME Ira Brooks		14. MOTHER'S MAIDEN NAME Annie Deel						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO 578-38-0382		17. INFORMANT Mrs. Leda L. St. Lawrence		Address 50715 Meadow Hill Rd., Silver Spring, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 162x		DUE TO (b)		METASTATIC CARCINOMA		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		DUE TO (c)		CARCINOMA OF LUNG		UNKNOWN		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from MARCH 24, 1966 , to DEC 18, 1967 , that (I) (we) last saw the deceased alive on DEC 12, 1967 , and that death occurred at 2 PM , from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
22a. SIGNATURE Arthur S. Bressler		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED DEC 16, 1967				
22c. PHYSICIAN'S NAME (Type) Arthur S. Bressler		22d. ADDRESS 10381 Lockwood Dr., Silver Spring, Md.						
23a. BURIAL CREMATION REMOVAL (Specify) Trans-urial		23b. DATE THEREOF Dec. 22, 1967		23c. NAME OF CEMETERY OR CREMATORIUM St. Lawrence Cemetery		23d. LOCATION (City, town, or county) (State) Sayville, New York		
24. FUNERAL DIRECTOR'S SIGNATURE John P. Shone		ADDRESS 100-102 Avenue		25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE Martha J. Hayes		
25. FUNERAL DIRECTOR'S SIGNATURE Carrie E. Thompson		ADDRESS 100-102 Avenue		DATE				



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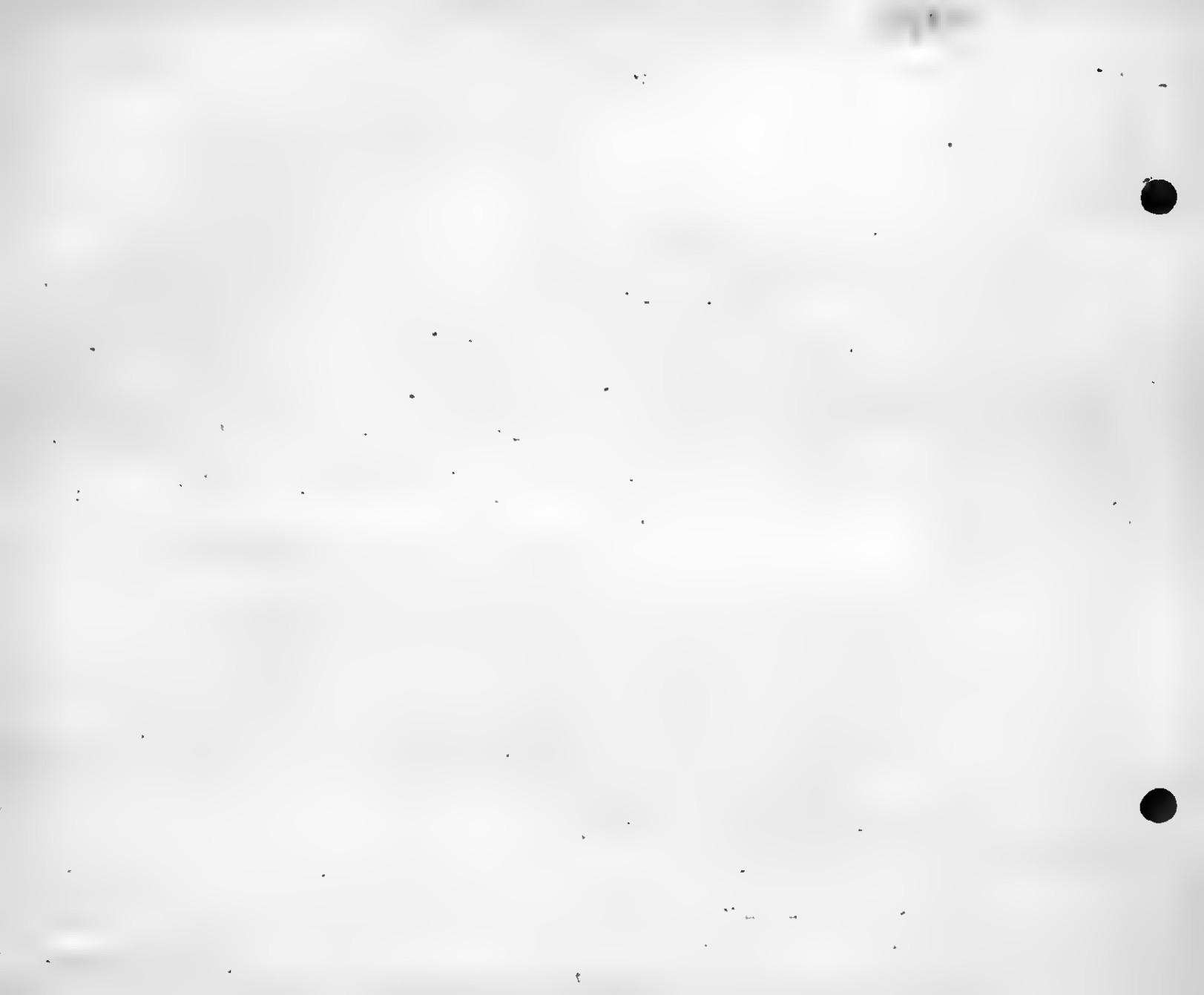
17153
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7b Film G396 1/12/68 kk

CERTIFICATE OF DEATH

17153

1. DECEASED NAME (Type or print)	First <i>Barkard</i>	Middle <i>Brosart</i>	Last	2a. DATE OF DEATH Month Year	2b. HOUR 22 2pm
3. SEX <i>Fe</i>	4. RACE <i>Wh.</i>	S. DATE OF BIRTH <i>12/09/79</i>	6. AGE (In years last birthday) YRS. <i>79</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery Co.</i>	10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Chesapeake Nursing & Conv. Center</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Waitress</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>6505 Bradley Blvd</i>	
14. FATHER'S NAME First <i>Unknown</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Kunigunda</i>	Middle <i></i>	Last <i>Meier</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO (Type give war or dates of service) <i>none</i>	17. INFORMANT <i>Mrs Richard Livingston Same as 13e</i>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Venous accident</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>					
DOUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis 3 yrs.</i>					
DOUE TO, OR AS A CONSEQUENCE OF (c) <i></i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>					
19a. DATE OF OPERATION <i></i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING (If either, notify medical examiner) <i></i>	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) <i></i>	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>June 1962</i> , to <i>Dec 27, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 26, 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Sanford J. Randall MD</i>	DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>12-27-67</i>
22d. PHYSICIAN'S NAME (Type) <i>S. J. RANDALL</i>	22e. ADDRESS <i>3001 Veasey Terr. N.W. D.C.</i>				
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>	23b. DATE <i>12-30-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>United German & French Cheektowaga New York</i>	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>	ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>	25a. REC'D BY REGISTRAR DATE <i>JAN 5 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles George</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

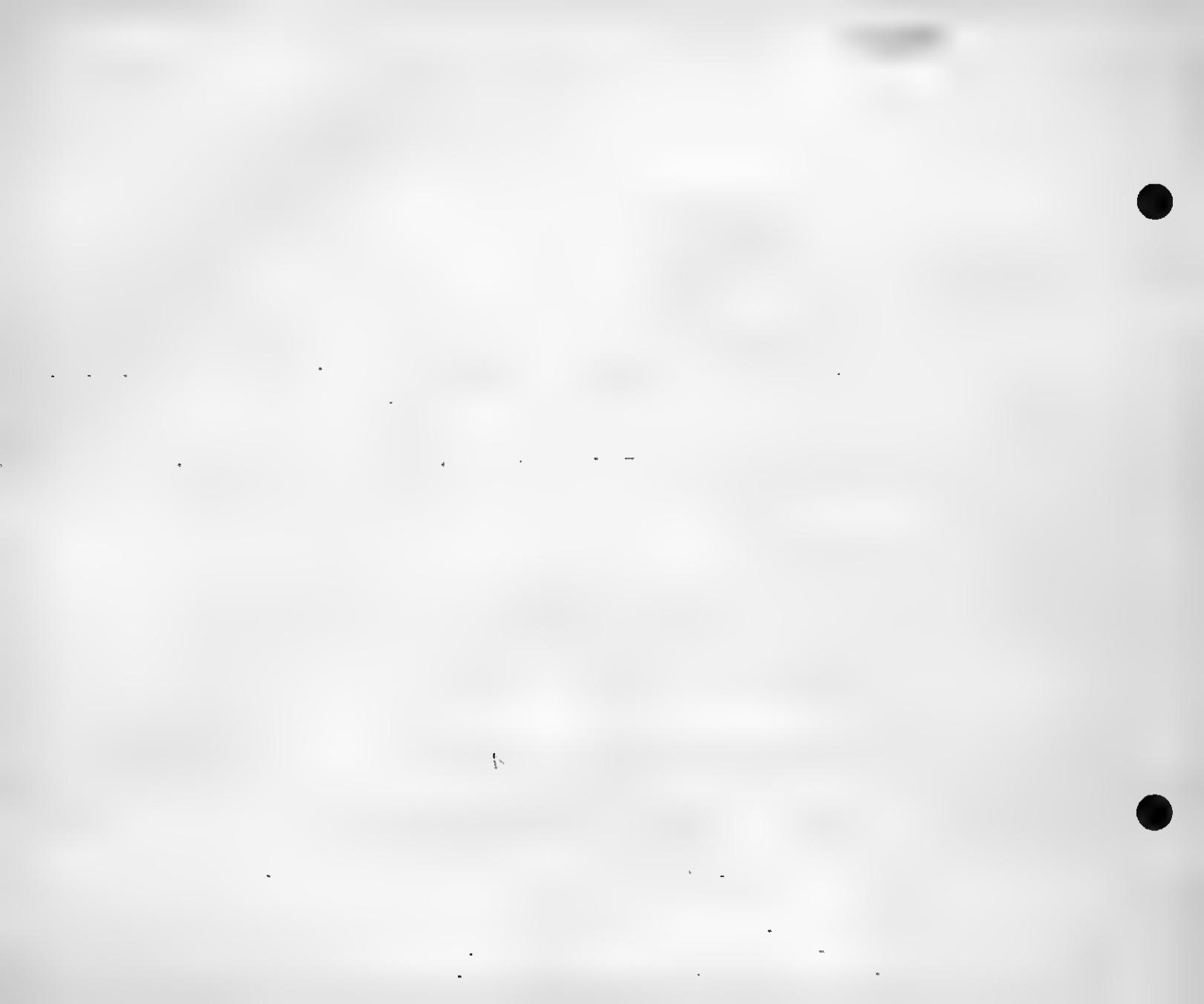
17158

CERTIFICATE OF DEATH

17154

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission d. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b One hour				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				
3. NAME OF DECEASED (Type or print) BERTHA		First L.	Middle BROWN			
4. DATE OF DEATH 12 26 1967		Month 12	Day 26			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			
8. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		9. DATE OF BIRTH 6-29-75				
10. BIRTHPLACE (County & State, or foreign country) Leesburgh Va.		11. AGE (In years lost birthday) 92 yrs				
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Theodore Ryon				
14. MOTHER'S MAIDEN NAME Annie Campbell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				
16. SOCIAL SECURITY NO. 578-52-0236		17. INFORMANT Address Paul B. Long 4905 Melinda Ct., Rockville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarct, acute		INTERVAL BETWEEN ONSET AND DEATH None				
DUE TO (b) Oclusion R.L. coronary artery		hours				
DUE TO (c) Generalized arteriosclerosis		years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Talmadge	20f. (City or town) Talmadge	(County) Howard	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from Dec 67 , 19 67 , to Dec 26, 1967 , that (I) (we) last saw the deceased alive on Dec 26, 1967 , and that death occurred at M , from causes and on the date stated above.						
22a. SIGNATURE Richard A. Yeter		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/26/67	
22c. PHYSICIAN'S NAME (Type) Richard A. Yeter		22d. ADDRESS Old Baltimore St. Clarendon, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Rental		23b. DATE THEREOF Dec. 29, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) Suitland, Maryland		(County) Howard
23e. FUNERAL DIRECTOR C. Glen Carter		ADDRESS 2434 Maria Ln.	23f. RECEIVED BY REGISTRAR DATE JAN 4 1968		23g. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						17155					
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs			c. LENGTH OF STAY IN 1b 15 Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs			d. STREET ADDRESS 8812 Maywood Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8812 Maywood Ave.									e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Elizabeth Mary Brown			First Elizabeth	Middle Mary	Last Brown	4. DATE OF DEATH 12 2 1967		Month 12	Day 2	Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH 9-8-05		9. AGE (in years last birthday) 62 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of work week, even if retired) Housewife & Clerk			10b. KIND OF BUSINESS OR INDUSTRY University			11. BIRTHPLACE (County & State, or foreign country) New Jersey			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Patrick Reynolds						14. MOTHER'S MAIDEN NAME Elizabeth Dunnigan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO			17. INFORMANT Wm. A. Brown Husband #2			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Promable Coronary Artery Thrombosis DUE TO 4001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH few hrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cirrhosis						19. WAS AN AUTOPSY PERFORMED? NO					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20b			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19									20f. (City or town) (County) (State) 20f		
21. I certify that (I) (This hospital) attended the deceased from March 1967 to 12/2 1967 , that (I) (we) last saw the deceased alive on 11/27 1967 , and that death occurred at 11/27 1967 M, from causes and on the date stated above						22a. DATE SIGNED 12/12/67					
22b. SIGNATURE H. Howard Seel			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>								
22c. PHYSICIAN'S NAME (Type) Robert A. Devol						22d. ADDRESS Devol Funeral Home Wash. D.C.					
23a. BURIAL / CREMATION, REMOVE (check) burial			23b. DATE THEREOF 12/5/67			23c. NAME OF CEMETERY OR CREMATORIAL Holy Sepulchre Cem.			23d. LOCATION (City or Town) (County) (State) Newark, N.J.		
24. FUNERAL DIRECTOR Robert A. Devol			ADDRESS Devol Funeral Home			25a. REC'D. REGISTRAR OCT 5 1967			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, place 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

1		17156											
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institutions Residencia before admission)											
a. COUNTY		b. STATE											
Montgomery		Maryland											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)											
Bethesda		Suburban Hospital											
d. LENGTH OF STAY IN TB		d. STREET ADDRESS											
19 hrs 15 min		RTI Box 208 Emory Grove Rd.											
e. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
Suburban Hospital													
f. FIRST MIDDLE LAST		g. DATE OF DEATH											
First Eric Lamont Brown		Month Dec Day 5 Year 1967											
Middle													
Last													
3. NAME OF DECEASED (Type or print)		4. DATE OF BIRTH											
Eric Lamont Brown		Dec 4, 1967											
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		B. DATE OF BIRTH					
Male		Colored		<input type="checkbox"/>		<input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
				<input type="checkbox"/>		<input type="checkbox"/>						Montgomery Co., Md. USA	
				<input type="checkbox"/>		<input type="checkbox"/>						12. CITIZEN OF WHAT COUNTRY?	
				<input type="checkbox"/>		<input type="checkbox"/>						19 15	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Brenda Jean Brown													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)		16. SOCIAL SECURITY NO. 17. INFORMANT											
		Brenda Jean Brown											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		Address											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity		INTERVAL BETWEEN ONSET AND DEATH											
1100													
DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b,													
DUE TO													
{ cause last. } (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e).													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
Hour a.m.				While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
p.m.		19											
21. I certify that (I) (this hospital) attended the deceased from Dec 4, 1967 to Dec 5, 1967 that (I) (we) last saw the deceased alive on Dec 5, 1967 and that death occurred at 9:10 AM, from the causes and on the date stated above.													
22a. SIGNATURE		22b. DATE SIGNED											
James A Davis Jr. M.D.		X											
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>											
JAMES A DAVIS JR.		22d. ADDRESS											
8218 Wisconsin Ave.		Bethesda - Montg. Md.											
23e. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)					
Suburban Hospital		12/7/67		Suburban Hospital		Bethesda - Montg.		Md.					
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR 25b. REG. STAR'S SIGNATURE											
Mrs. Amelia C Carter, Administrator (EA)		DEC 11 1967 Charles Judge											



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me, **burial permit** should be obtained from the State Dept. of Health prior to burial, tremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN b. 52 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
f. STREET ADDRESS 3205 Olds Drive		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kermit King BROWN		4. DATE OF DEATH Month Day Year December 29 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jul. 12, 1918
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (County & State or foreign country) North Dakota	
13. FATHER'S NAME Harry Shelby		14. MOTHER'S MAIDEN NAME Alice Marie Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1941-1944		16. SOCIAL SECURITY NO.	
		17. INFORMANT Falls Church, Va. Address Mrs. Elizabeth C. Brown, 3205 Olds Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma with widespread lymphatic metastases INTERVAL BETWEEN ONSET AND DEATH + 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJRY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 7, 1967 , to Dec. 29, 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 29, 1967 , and that death occurred at 935AM , from causes and on the date stated above			
22a. SIGNATURE <i>D. R. Foreman, M.D.</i>		22b. DATE SIGNED Dec. 30, 1967	
22c. PHYSICIAN'S NAME (Type) D. R. FOREMAN, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF	
		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	
23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR <i>C. M. Grancey</i> ADDRESS Murphy Funeral Home, 3524 Columbia Pike Arlington, Virginia		25a. REC'D. BY REGISTRAR JAN 4 1968	25b. DECEASED'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17158

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages and 2, and file with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.*Dr Charles H. Morse, M.D., Montgomery County, Md., Examiner of Deaths*

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
<i>Montgomery</i> MARYLAND		<i>Md</i> <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7344 Carroll Avenue</i>		d. STREET ADDRESS <i>7344 Carroll Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Mos</i>	Middle <i>S.</i>	Last <i>Brown</i>
4. DATE OF DEATH Month <i>12</i>	Day <i>30</i>	Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Grocer (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
9. AGE (In years last birthday) <i>88 yrs.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Rippon West Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>		13. FATHER'S NAME <i>John W. Brown</i>	
14. MOTHER'S MAIDEN NAME <i>Catherine Finnell</i>		15. SOCIAL SECURITY NO. <i>57701 9853</i>	
16. INFORMANT <i>Rev. Lilia K. Montgomery (same as #2)</i>		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Adams carcinoma of Prostate with Metastasis.</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2 yrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost</i>		(b) <i>Ch. deg. Squamous - see Decomp -</i>	
(c)		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>none</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg. etc.) <i>none</i>
20f. (City or town) <i>Adelphi</i>		(County) (State) <i>Md</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>2/6</i> , 19 <i>61</i> to <i>12/30</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>2/21</i> , 19 <i>67</i> , and that death occurred at <i>9:12</i> M. from causes and on the date stated above		22b. DATE SIGNED <i>12/30/67</i>	
22a. SIGNATURE <i>H. J. Morse</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>H. J. Morse M.D.</i>		22d. ADDRESS <i>7030 Carroll Ave Takoma Park Md</i>	
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan 2, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>George Washington Cem.</i>
24. FUNERAL DIRECTOR <i>Takoma Funeral Home of Walter, 254 Carroll St N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 4 1968</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>James J. Morse</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH						17159		
1 PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>			SILVER SPRING MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN lb <i>3 DAYS</i>			b. COUNTY <i>MONTGOMERY</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross</i>			d. STREET ADDRESS <i>8407 11th AVE.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) <i>LYDIA</i>		First <i>LYDIA</i>	Middle <i>M.</i>	Last <i>BRYANT</i>	4 DATE OF DEATH <i>DECEMBER 6 1967</i>	Month <i>December</i>	Day <i>6</i>	Year <i>1967</i>
5 SEX <i>Female</i>		6 COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/1/88</i>	9. AGE (In years last birthday) <i>79 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>VIRGINIA</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jonathan Bryant</i>					14. MOTHER'S MAIDEN NAME <i>Mary Ann Weaver</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Charles W. Bryant 8407 11th Ave Sil Sp</i>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Perforator Pneumonia</i> DUE TO <i>Proteus Mirabilis pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>Diphtheria Mellitus, late onset</i></p> <p>(b) <i>Diabetes Mellitus, late onset</i> DUE TO <i>Generalized Arteriosclerosis</i></p> <p>(c)</p>								
INTERVAL BETWEEN ONSET AND DEATH <i>few weeks</i> <i>few days</i> <i>1 year +</i> <i>Years</i>								
<p>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Tully</i> (County) <i>Charles W. Bryant</i> (State) <i>MD</i>	
<p>21. I certify that (I) (this hospital) attended the deceased from <i>July</i>, 19<i>67</i>, to <i>Dec. 6</i>, 19<i>67</i>, that (I) (we) last saw the deceased alive on <i>Dec. 6 1967</i>, and that death occurred at <i>4:30 P.M.</i> from causes and on the date stated above.</p>								
22a. SIGNATURE <i>Hugo G. Graziani</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>12/6/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>Hugo G. Graziani, MD</i>			22d. ADDRESS <i>10101 Georgia Ave SS, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>12-10-1967</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Providence Meth. Church</i>		
24. FUNERAL DIRECTOR <i>Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland</i>						23d. LOCATION (City or Town) <i>Chiltons</i> (County) <i>Charles W. Bryant</i> (State) <i>Virginia</i>		
						25a. REC'D. BY REGISTRAR <i>DEC 11 1967</i>		
						25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE New York		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 50 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Far Rockaway					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 6983 Hillmyer Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Jessie		First (none)	Middle 	Last BUCHANON	4. DATE OF DEATH December 3 1967	Month December	Day 3	Year 1967	
S. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 1925	9. AGE (In years last birthday) 42 yrs	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS Days 	Hours 	Min
10a. US JAI OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Riverview, Alabama		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Buchanon		14. MOTHER'S MAIDEN NAME Blannie Mae Wells							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1950-1967		16. SOCIAL SECURITY NO. 423 18 4595		17. INFORMANT Far Rockaway, N.Y. Address Navy Records					
18. CAUSE OF DEATH (Enter ony one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO stating the underlying cause last. (c) DUE TO		Bronchiogenic carcinoma				INTERVA. BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (A) (this hospital) attended the deceased from Oct. 18, 1967 , to Dec. 3, 1967 , that (X) (we) last saw the deceased alive on Dec. 3, 1967 , and that death occurred at 5:43 P.M. from causes and on the date stated above.									
22a. S. SIGNATURE Mitchell Mills		M.D. ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 5, 1967			
22c. PHYSICIAN'S NAME (Type) Mitchell Mills, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-67		23c. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery		23d. LOCATION (City or Town) Riverview (County) Alabama (State)			
24. FUNERAL DIRECTOR Ward-Funeral-Home		ADDRESS Falls Church		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Fairfax--Alabama-Funeral Home, Falls Church									
				DATE DEC 11 1967		Charles Judge			
				Va.					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 through 9 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) d. STATE <i>Maryland</i>		e. COUNTY <i>Baltimore</i>	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>9316 Piney Br. Rd.</i>			
						d. STREET ADDRESS <i>SilverSprings</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Leona</i>	Middle <i>Burdett</i>	Last <i>Burdett</i>	4 DATE OF DEATH <i>Dec 26 1967</i>	Month <i>Dec</i>	Doy <i>26</i>	Year <i>1967</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	8 DATE OF BIRTH <i>1896 Sept 16</i>	9. AGE (In years last birthday) <i>71 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <i>Europe - Lithuania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Chaim Kobre</i>		14. MOTHER'S MARRIED NAME <i>Rachel Gentis</i>		15. ADDRESS					
16. SOCIAL SECURITY NO <i>578-48-6029</i>		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i>		INTERVAL BETWEEN DEATH AND DEATH			
1538				DUE TO (b) <i>Carcinoma of Colon</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				(c)					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE MDW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office, bldg, etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1967</i> to <i>12-26, 1967</i> that (I) (we) last saw the deceased alive on <i>12-25 1967</i> , and that death occurred at <i>1115A.M.</i> from causes and on the date stated above		22a. SIGNATURE <i>Gilbert B. Cushing</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR	22b. DATE SIGNED <i>12-26-67</i>	22c. ADDRESS <i>Gilbert B. Cushing</i>	22d. STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-27-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Cemetery</i>	23d. LOCATION (City or Town) <i>Hyattsville, Maryland</i>	(County) <i>Maryland</i>	(State) <i>MD</i>			
24. FUNERAL DIRECTOR <i>Bernard Danzansky & Sons</i> 3501 14th St. N.W. Washington, D.C. 20010		25a. REC'D. BY REG. STRAN DATE <i>DEC 28 1967</i>		25b. REGISTRAR'S SIGNATURE <i>over judge</i>					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If copy delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

Items 18&21 Film 396 MARYLAND STATE DEPARTMENT OF HEALTH
12-29-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21207

17166

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17162

1 PLACE OF DEATH a COUNTY MONTGOMERY		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) b STATE MARYLAND	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c LENGTH OF STAY IN 1b 20 YRS	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt 2 GOOD HOPE Rd		e STREET ADDRESS Rt 2, GOOD HOPE Rd	
3 NAME OF DECEASED (First Middle Last) (Type or print) TENCIE (NMN) BURTON		4 DATE OF DEATH Month Day Year 12 - 12 1967	
5 SEX FEMALE	6 COLOR OR RACE NEGRO	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH Sept. 24, 1908
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY NORTH CAROLINA	
11b BIRTHPLACE (State or foreign country) NORTH CAROLINA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME JOHN THORP		14 MOTHER'S MAIDEN NAME Unk.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 17 INFORMANT DAUGHTER	
		Address SAME	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute coronary insufficiency with		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO 4801 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)			
DUE TO (c)		severe cardiomegaly and severe	
		intracranial atherosclerosis	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF MURDER Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Peep		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. PEEP, M.D., Rockville		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City, town or county) Dec. 12, 1967	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF Dec. 16, 1967	
23c NAME OF CEMETERY OR CREMATORIUM Good Hope Cemetery		23d LOCATION (City or Town) (County) (State) Silver Spring Montg. Md.	
24 FUNERAL DIRECTOR Robert L. Snowden Rockville, Md.		ADDRESS 25a REG'D BY REC'D STRAR DATE DEC 21 1967	
		25b REGISTRAR'S SIGNATURE Charles Jagger	

1. $\{x_i\}_{i=1}^n$ is a sample from $f(x)$
2. $\hat{f}_n(x) = \frac{1}{n} \sum_{i=1}^n K_n(x - x_i)$
3. $K_n(x) = \frac{1}{n} \sum_{i=1}^n \delta_{x_i}(x)$
4. $\hat{f}_n(x) = \frac{1}{n} \sum_{i=1}^n \delta_{x_i}(x) = \frac{1}{n} \sum_{i=1}^n \int_{\mathbb{R}} \delta_{x_i}(y) f_n(y) dy$
 $\hat{f}_n(x) = \int_{\mathbb{R}} f_n(y) \sum_{i=1}^n \delta_{x_i}(y) dy$

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

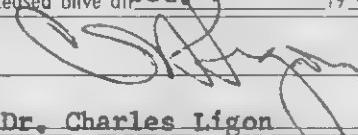
1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
<i>Montgomery Maryland</i>		<i>Maryland Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
<i>Takoma Park D.O.A.</i>		<i>Adelphi Washington 2409 Lyndon St</i>	
3 NAME OF DECEASED (Type or print) First Middle Last		4 DATE OF DEATH Month Day Year	
<i>Raymond Ignatius Cady</i>		12 3 1967	
5 SEX MALE		6 COLOR OR RACE W	
7 MARRIED <input checked="" type="checkbox"/> WIDOWED		8 DATE OF BIRTH 3-1-23	
9 AGE (in years lost birthday) 44 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRWAYS OPERATIONS SPEC		10b. KIND OF BUSINESS OR INDUSTRY F.A.A. Fed. Govt.	
11 BIRTHPL. ACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME <i>John Bernard Cady</i>		14. MOTHER'S Maiden Name <i>Elsie Ackerson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. I	
17. INFORMANT Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) Coronary Artery Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D., Takoma		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, County, State)	
22. DATE SIGNED DEC. 3, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 6, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR <i>Takoma Funeral Home Takoma Park MD</i>		25. ADDRESS <i>2540 Lyndon St</i>	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE DATE DEC 7 1967	

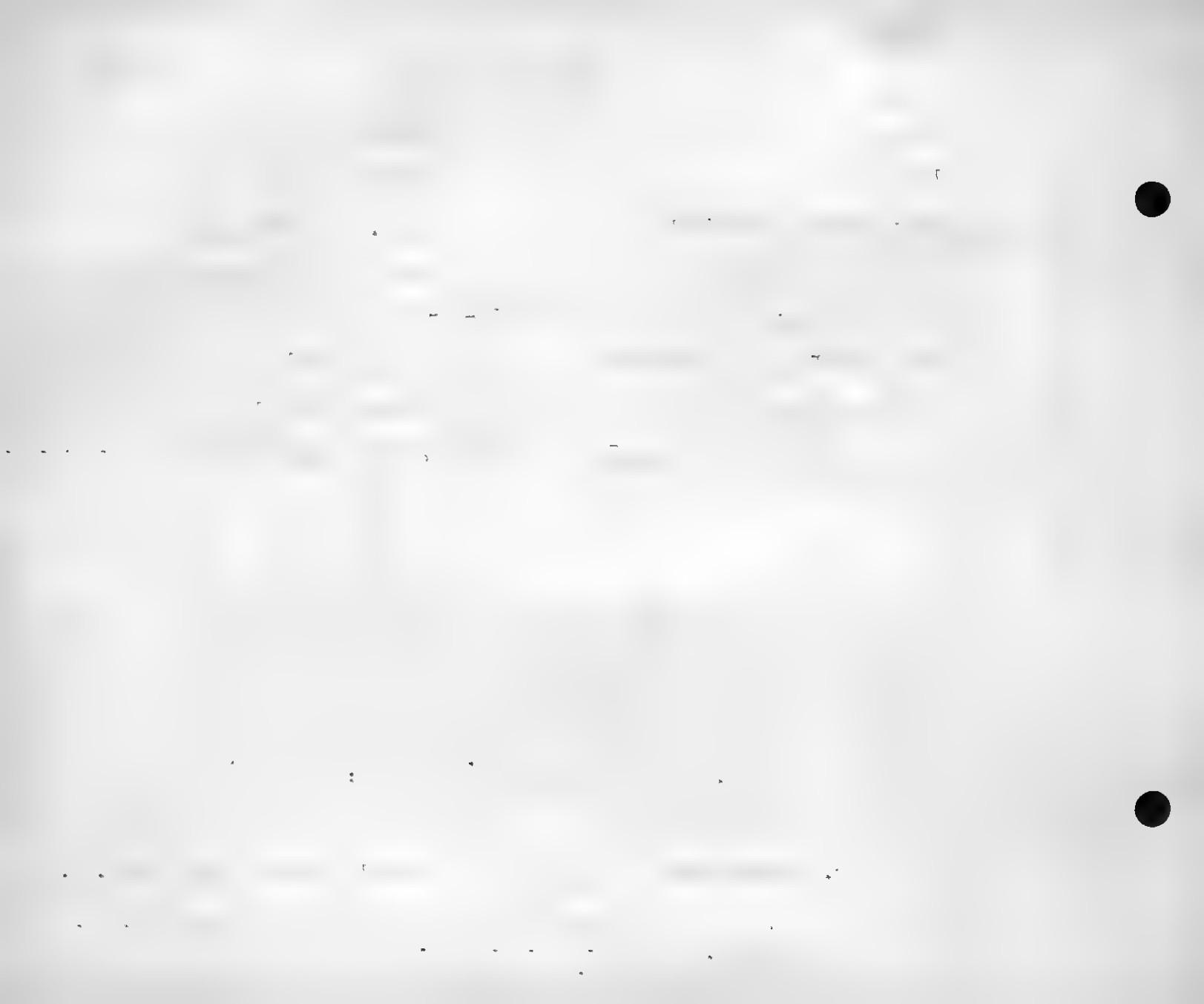


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN lb 5 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		
3. NAME OF DECEASED (Type or print) Giosue			f. STREET ADDRESS 15811 Mt. Everest Lane		
3. SEX Male	4. FIRST NAME Giosue	5. MIDDLE NAME Joe	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 12-17-01
9. DATE OF DEATH December 9 1967			9. AGE (in years lost birthday) 65 yrs.		
10. US. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Baker			10b. KIND OF BUSINESS OR INDUSTRY Federal Bakery		
11. BIRTHPLACE (County & State, or foreign country) Switzerland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Giosue Canova			14. MOTHER'S MAIDEN NAME Catherine Trippel		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 577-07-1804		
17. INFORMANT Frank Greene			17. INFORMANT Montgomery General Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X <i>Examination</i>			19. INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Obstruction of prostate					
DUE TO (b) 					
DUE TO (c) 					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 4 1967 to Dec. 9 1967 , that (I) (we) last saw the deceased alive on Dec. 9 1967 , and that death occurred at 6:15 AM , from causes and on the date stated above.					
22a. SIGNATURE 			22b. DATED SIGNED 12-10-67		
22c. PHYSICIAN'S NAME (Type) Dr. Charles Ligon			22d. ADDRESS Medical Center, Sandy Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF Dec. 10, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Crematory	23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Md.
24. FUNERAL DIRECTOR Glen Carter, Inc.			25a. ADDRESS 8434 Ga. Ave. S.S. Md.	25b. REF'D BY REG STRAR C. Glen Carter	25b. REG STRAR'S SIGNATURE Charles Judge
25c. DATE DEC 13 1967					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) d. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c LENGTH OF STAY IN 1b <i>1 day</i>			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>						d. STREET ADDRESS <i>11601 Idlewood Road</i>					
3 NAME OF DECEASED (Type or print) <i>Hugh Dorsey Carmichael</i>			First	Middle	Last	4. DATE OF DEATH Month <i>December</i> Day <i>16</i> Year <i>1967</i>			IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>		
5 SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>Jan. 1, 1919</i>			9. AGE (in years last birthday) <i>53 yrs</i>		
10 DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>						10b KIND OF BUSINESS OR INDUSTRY <i>Doctors Hospital</i>			11. BIRTHPLACE (Country & State, or foreign country) <i>Georgia</i>		
13. FATHER'S NAME <i>Hugh B. Carmichael</i>						14. MOTHER'S MAIDEN NAME <i>Elfie Odom</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>						16. SOCIAL SECURITY NO <i>254-18-7907</i>			17. INFORMANT <i>Lucille Carmichael</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						19. ADDRESS <i>11601 Idlewood Road Silver Spring, Maryland</i>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dehydration and infection</i> DUE TO <i>4201</i>						INTERVAL BETWEEN ONSET AND DEATH <i>one day</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Dec 15 1967</i>			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)			20f (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 15, 1967</i> to <i>Dec 16, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 15, 1967</i> , and that death occurred at <i>11:00 AM</i> , from causes and on the date stated above.											
22a. SIGNATURE <i>B. Blaine H. Biggs</i>						22b. DATE SIGNED <i>12/16/1967</i>					
22c. PHYSICIAN'S NAME (Type) <i>BLAINE H. BIGGS.</i>						22d. ADDRESS <i>8641 Columbia Rd, Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Dec. 19, 1967</i>			23c. NAME OF CEMETERY OR CREMATORIAL FACILITY <i>Parklawn Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>		
24. FUNERAL DIRECTOR <i>John W. Blaine H. Biggs, Inc.</i>						24a. ADDRESS <i>8474 Georgia Avenue</i>			24b. REC'D BY REGISTRAR <i>DEC 28 1967</i>		
25a. DATE <i>Blaine H. Biggs, Inc.</i>						25b. REGISTRAR'S SIGNATURE <i>James J. Blaine H. Biggs</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

*71'80

CERTIFICATE OF DEATH

17166

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>2 days</u>	
d. NAME OF HOSPITAL OR INST TUITION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>1200 Clagett Dr.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward</u>	First <u>A</u>	Middle <u>Carter</u>	Last <u>Dec 26 1967</u>
4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1967</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <u>3/6/1895</u>	9. AGE (In years last birthday) <u>72 yrs</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Benjamin Carter</u>	14. MOTHER'S MAIDEN NAME <u>Elizabeth Mathews</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>217-01-3774A</u>	17. INFORMANT Address <u>Myrtle A. Mills-daughter-same item + 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Cancer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Moz.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		DUE TO DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>67</u> , to <u>12-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-25 1967</u> , and that death occurred at <u>11 AM</u> , from causes and on the date stated above.		20f. (City or town) <u>Derwood</u> (County) <u>Montgomery</u> (State) <u>Maryland</u>	
22a. SIGNATURE <u>JHC</u>		22b. DATE SIGNED <u>12/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr James T. McCormick</u>		22d. ADDRESS <u>5218 Wisconsin Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, BURIALITY <u>Buriality</u>		23b. DATE THEREOF <u>12/28/67</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Derwood</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. ADDRESS <u>Rockville, Maryland</u> 25b. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>JAN 2 1968</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17167

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) a. STATE	
Dorothy County Maryland		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
County Clerk		3 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Bethesda, Silver Spring Nursing Home, 1709 Caplinger Rd.		Silver Spring	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year	
First MIDDLE LAST MARY Eileen CARTER		Month Day Year Dec. 10 1967	
5. SEX Fe.		6. COLOR OR RACE W	
7. MARRIED WIDOWED		8. DATE OF BIRTH NEVER MARRIED DIVORCED 1846, 1915	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) President		10b. KIND OF BUSINESS OR INDUSTRY Carter Const. Co.	
11. BIRTHPLACE (County & State, or foreign country) UTAH.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Dilbert Nebeker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Nursing Carter 11709 Caplinger Rd. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1110	
		DUE TO (b) Cerebral Metastasis	
		DUE TO (c) Carcinoma Breast	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19		20e. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1964, 19 to 12-10, 1967, that (I) (we) last saw the deceased alive on 12-10, 1967, and that death occurred at 235 P.M. from causes and on the date stated above.		22b. DATE/SIGNED 12/10/67.	
22a. SIGNATURE Dilbert J. Kramer - M.D.		22b. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) ROBERT J. KRAMER		22d. ADDRESS 8484 16th St. 88 Nd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec. 10, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Port Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR Clark E. Wilson, Inc.		25a. ADDRESS Georgia Avenue	
Warner E. Pumphrey, Inc.		25b. REGISTRAR'S SIGNATURE Judge	
		25c. REC'D BY REGISTRAR DATE DEC 13 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2 Film G396 7/12/68 loc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

30
30
Montgomery
BETHESDA
Suburbans
15

If any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>15 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospice give street address) <i>Suburbans</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Suburbans</i>	
3. NAME OF DECEASED (Type or print) <i>Florence N. Castle</i>		4. DATE OF DEATH Month Day Year <i>Dec. 27 1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> NEVER MARRIED DIVORCED	8. DATE OF BIRTH <i>3/25/1917</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) <i>Baby Nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>W. VA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>P. Z. CASTLE</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA SELLERS</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Hosp. RECORDS</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <i>Myocardial infarction, old & recent, anterior left ventricle and interventricular septum</i> DUE TO <i>marked coronary arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>			
INTERVAL BETWEEN ONSET AND DEATH <i>48 hr.</i> <i>7 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Fracture of Right Hip.</i>			
20a. EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Fell in nursing home causing fracture of RT hip</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>am 12/25 1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i>nursing home</i>		20f. (City or town) (County) (State) <i>Kensington-Montgomery Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, town or county) <i>BETHESDA, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-1-68</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Glover Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Glover Gap Wetzel W. Va.</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey, 7557 Wisconsin Ave.</i>		ADDRESS Bethesda, Md.	
		25a. REC'D BY REGISTRAR DATE JAN 5 1968	
		25b. REGISTRAR'S SIGNATURE <i>Charles J. George</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	c LENGTH OF STAY IN lb <i>5 days</i>	b. COUNTY <i>Montgomery</i>	c CITY OR TOWN (If out of corporate limits, write RURA, and give nearest town) <i>Takoma Park</i>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San & Hosp.</i>		d STREET ADDRESS <i>7313 Flower Ave.</i>	
3 NAME OF DECEASED (Type or print) <i>Bertha</i>		First <i>E.</i>	Middle <i>? Chapin</i>
4 DATE OF DEATH <i>December 26 1967</i>	Month <i>Dec</i>	Doy <i>26</i>	Year <i>1967</i>
S. SEX <i>F</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH <i>Jan. 8 1887</i>		9 AGE (in years lost birthday) <i>90 yrs.</i>	10 IF UNDER 1 YEAR Months <i>0</i>
10b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11 BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>	12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Dwight Anderson</i>		14 MOTHER'S MAIDEN NAME <i>Clarassia Rockwell</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO <i>577-07-2013</i>	17 INFORMANT <i>Chapin, 211 Kinderhook Lane P.Med. Records movie, inc., Inc.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Takoma Park</i>		(County) (State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>12/18/1967</i> to <i>12/26/1967</i> , that (I) (we) last saw the deceased alive on <i>12/20/1967</i> , and that death occurred at <i>M</i> , from causes and on the date stated above			
22a. SIGNATURE <i>H. T. Morse</i>		MD ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
22b. DATE SIGNED <i>12/26/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>H. T. Morse</i>		22d. ADDRESS <i>7030 Carrollton Takoma Park Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>"</i>		23b. DATE THEREOF <i>Dec 26 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>+ P. + 100th Cemetery</i>
23d. LOCATION (City or Town) <i>Bethesda, Md.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>Farmer E. Lumpkin, Inc.</i>		24b. ADDRESS <i>8433 Columbia Rd. N.E. Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR <i>JAN 2 1968</i>
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

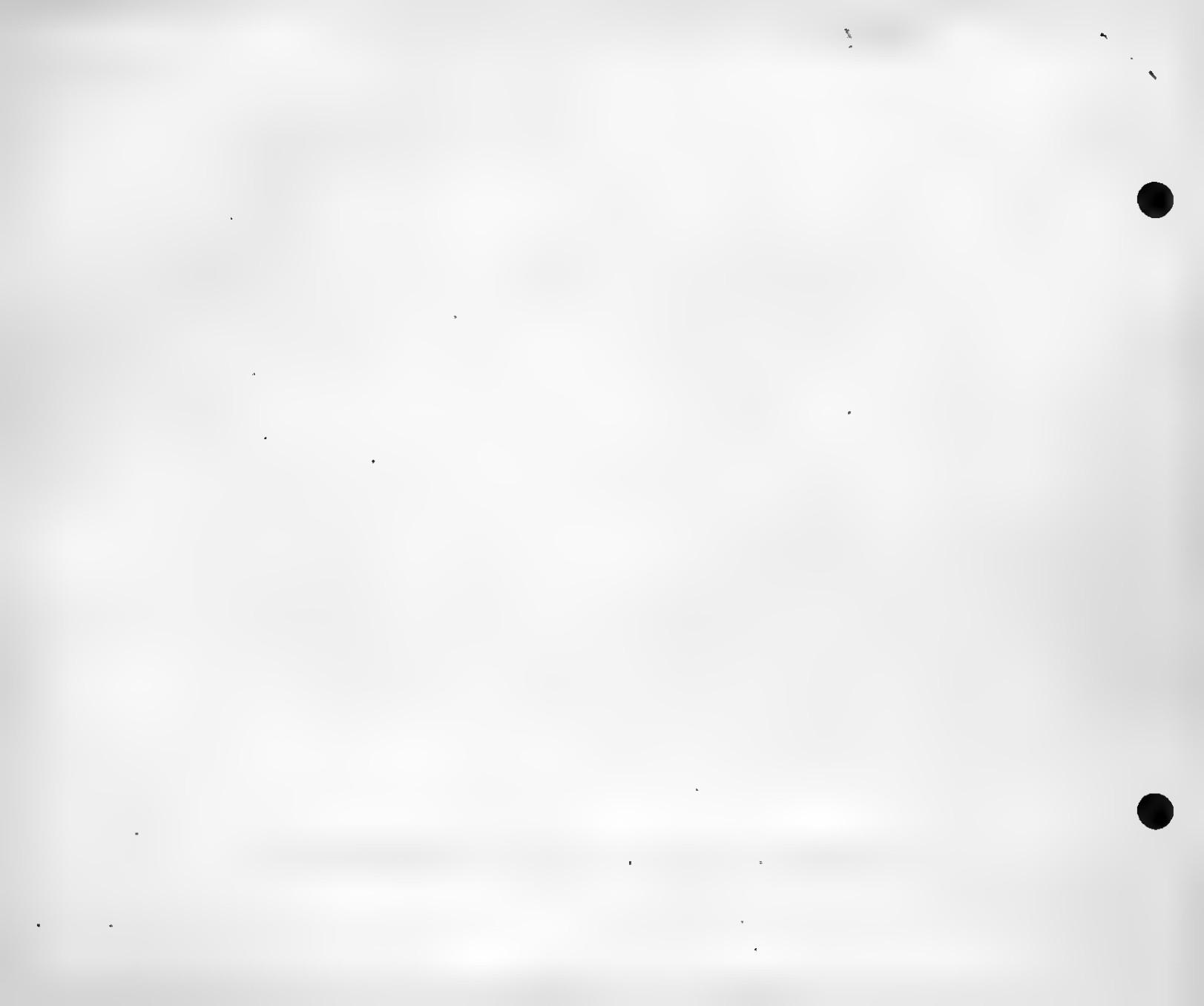
CERTIFICATE OF DEATH

17170

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. *Paper and ink should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.*

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
a. COUNTY Montgomery MARYLAND		a. STATE South Carolina	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 7 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myrtle Beach		d. STREET ADDRESS 1406 North Chester St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Christopher Scott CHASTAIN		First	Middle
3. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED	8. NEVER MARRIED <input type="checkbox"/>
9. DATE OF BIRTH Nov. 15, 1967		9. AGE (In years lost birthday) yrs 28	10. IF UNDER 1 YEAR Months 28
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) Myrtle Beach, S. C.
13. FATHER'S NAME Dwight H. Chastain		14. MOTHER'S MAIDEN NAME Tonda Loy Fernandez	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	17. INFORMANT Chester St. Address Myrtle Beach, SC SGT Dwight H. Chastain, USAF, 1406 North
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7593 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		MULTIPLE CONGENITAL DEFECTS INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDER, YING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office b dg, etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 6, 1967 , to Dec. 13, 1967 , that (I) (we) last saw the deceased alive on Dec. 13, 1967 , and that death occurred at 240A M. from causes and on the date stated above.		22b. DATE SIGNED Dec. 13, 1967	
22a. SIGNATURE <i>Gene P. Swartz</i>		MD ATTENDING PHYS <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) GENE P. SWARTZ MD.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-16-67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Jacksonville Mem. Gardens, Clay County, Fla.
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE DEC 18 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use of the burial-transit permit. Then please remove carbon paper, fold and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY Montgomery Maryland				2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 159 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		d. STREET ADDRESS 5564 Maxwell Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Ireda	Middle June	Lost	4. DATE OF DEATH Month December	Month 5	Doy 1967
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1942	9. AGE (In years last birthday) 25 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) California		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Harris				14. MOTHER'S MAIDEN NAME Myrtle Blodgett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Not available		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> INTERVAL BETWEEN ONSET AND DEATH 18 hours 2045 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <u>Multiple pulmonary emboli</u> 1 month lost } DUE TO (c) <u>Acute myelogenous leukemia</u> 6 months							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hepatic failure, probable drug toxicity (weeks)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 5	(County) (State)
21. I certify that (1) (this hospital) attended the deceased from June 29, 1967, to December 5, 1967, that (1) (we) last saw the deceased alive on December 5, 1967, and that death occurred at 6:03 P.M. from causes and on the date stated above							
22a. SIGNATURE <i>David L. Lilien</i>				22b. DATE SIGNED AM M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 5 December 1967			
22c. PHYSICIAN'S NAME (Type) David L. Lilien, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/11/67		23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Memorial Pk. Cemetery, Tacoma, Washington		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland				25a. RECD BY REGISTRAR DATE DEC 11 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>	



FOR STATE
HEALTH DEPT.

17176
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit file pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17172

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) d. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN MD <i>D.O.A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
3. NAME OF DECEASED (Type or print) <i>Thomas</i>		First <i>Christison</i>	Middle <i></i>
3. NAME OF DECEASED (Type or print) <i>Thomas</i>		Last <i>Christison</i>	4. DATE OF DEATH <i>12-29-67</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>Br</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. US. ARMED OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William A. Christison</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Talbot</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address <i>Mother-Katherine -</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Drowning</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>3 min?</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Found at bottom of YMCA Swimming Pool</i>	
20c. TIME OF INJURY Month, Day, Year <i>11:25 am 12/29 1967</i>		20d. INJURY OCCURRED At home <input type="checkbox"/> At work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, off bldg etc.) <i>Swimming Pool</i>
20f. (City or town) <i>Bethesda, Montgomery Md</i>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Bell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i></i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i></i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <i></i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>12/30/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cemetery</i>
23d. LOCATION (City or Town) <i>Colmar Manor</i>		(County) (State) <i>PG Md</i>	
24. FUNERAL DIRECTOR <i>F. Gagich's Sons Hyattsville, Md</i>		25a. REC'D BY REGISTRAR ADDRESS <i></i>	25b. REGISTRAR'S SIGNATURE <i>Judge</i>
		DATE JAN 4 1968	
VR ATSM (9) 6M 1/67			

25

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17173

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY	Montgomery		
Montgomery				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Boyd's - Rural					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM?			
Rural - Boyd's								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Mary		L	C	Clagett	Dec.	19	1967				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS				
Female		White		Oct. 21-1897	70	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
House wife				Maryland		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Edward O. Henderson		Ida Mae Cowell									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT		Address					
No		220-44-8169		Miss Kathleen Clagett		Baltimore Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Months									
77 DUE TO		UREMIA - Chronic									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Pyonephrosis - Pyonephrosis Years									
(b) DUE TO		Autevico sclevaris -									
(c)		Diabetes Mellitus									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Dec. 3, 1967, to Dec 19, 67, that I last saw the deceased alive on Dec. 16, 1967, and that death occurred at 6 p.m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)								DATE SIGNED	
ACTUAL SIGNATURE		Jack Schumacher, M.D. 105 Russell Ave. 12-20-									
PHYSICIAN'S NAME (Type)		Jack Schumacher Gaithersburg, Md. 67									
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town or county)		(State)			
Burial		12/21/67		St Mary's		Rockville		Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS									
William B. Hilton, Barnesville, Md.											
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									
DATE DEC 26 1967		Charles Judge									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17178

CERTIFICATE OF DEATH

17176

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE	
Montgomery Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Kensington		Wheaton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Kensington Gardens Sanitorium			
3. NAME OF DECEASED (Type or print)	First Beulah	Middle Anna	4. DATE OF DEATH Month Dec, Day 19 Year 1967
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 16 1880
		NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 87 yrs
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland	
		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James F. Hardy		14. MOTHER'S MAIDEN NAME May E. Sheehy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 217-52-8103	
		17. INFORMANT John H. Hardy	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		Pulmonary edema DUE TO Pneumonia DUE TO generalized arteriosclerosis	
		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1/67, 19, to 12/19/67, 19, that (I) (we) last saw the deceased alive on 12/18/67, 19, and that death occurred at 5:35 P.M. from causes and on the date stated above.			
22a SIGNATURE Patrick C. Jameson		22b DATE SIGNED 12/19/67	
22c PHYSICIAN'S NAME (Type) Patrick C. Jameson		22d ADDRESS 11718 Georgia Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 22, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR John R. Thompson, Inc.		25a. REC'D BY REGISTRAR DEC 27 1967	
		25b. REGISTRAR'S SIGNATURE Reagan Judge	

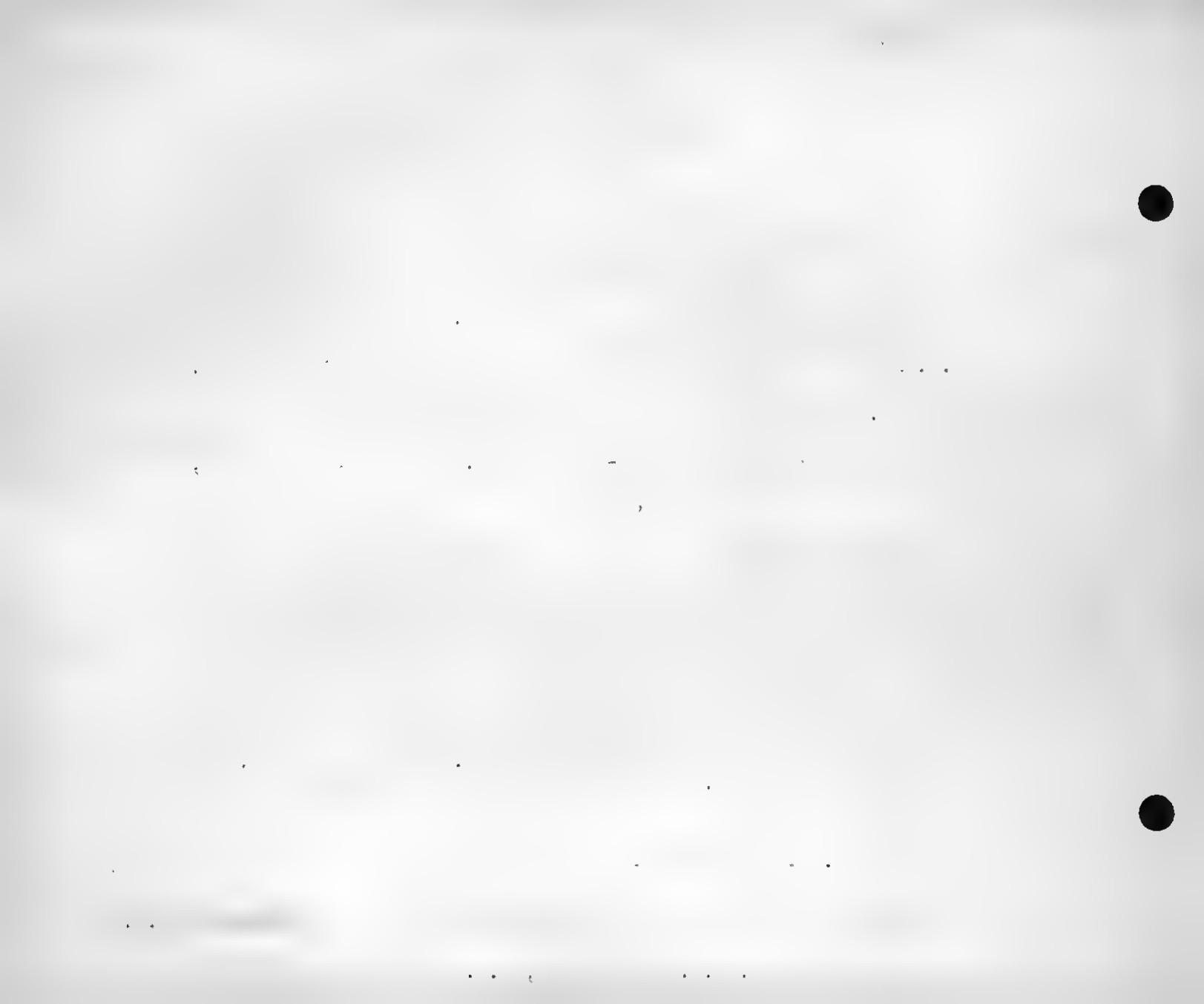


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 10401 Grosvenor Place		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Cyrus		First	Middle	4. DATE OF DEATH December 7, 1967	Month	Doy	Year	
S. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1913	9. AGE (in years last birthday) 54 yrs	IF UNDER 1 YEAR Months Days Hours Min		
10a. USIA OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Manilla, Phillipine Is.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Cyrus W. Cole				14. MOTHER'S MAIDEN NAME Julianna Busby				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1935-1965		16. SOCIAL SECURITY NO. 561-54-8317		17. INFORMANT Mrs. Marjorie Garland Cole,		Address 10401 Grosvenor Pl.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung with metastases		DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVA. BETWEEN ONSET AND DEATH		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Naval Hospital, Bethesda, Md.	(County) Maryland	(State) D.C.
21. I certify that (I) (this hospital) attended the deceased from Nov. 12, 1967 , to Dec. 7, 1967 , that (A) (we) last saw the deceased alive on Dec. 7, 1967 , and that death occurred at Q515 M. from causes and on the date stated above								
22a. SIGNATURE JR Fletcher		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>	DATE SIGNED 8 Dec 67	
22c. PHYSICIAN'S NAME (Type) J. R. FLETCHER MD.		22d. ADDRESS Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec. 9, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland		
24. FUNERAL DIRECTOR Joseph Gawlers Sons		ADDRESS 5133 Wisconsin Ave. N.W., Washington, D.C.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE DEC 15 1967		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17176

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN lb <i>338-W. Edmonston St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>338-W. Edmonston St.</i>		e. STREET ADDRESS <i>338-W. Edmonston St.</i>	
3 NAME OF DECEASED (Type or print) <i>Elizabeth Marie Collier</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary-Morris Decorators</i>		8 DATE OF BIRTH <i>5/5/18</i>	
10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>49 yrs</i>	
13. FATHER'S NAME <i>John W. Cross</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address <i>Wilburn P. Collier, Jr. same as #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Aspiration Cystic disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Fatty Metam., Fibrosis of Liver Acute</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>2h.?</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <i>12/17/67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>12/20/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Manassas Cemetery</i>
23d. LOCATION (City or Town) (County) (State) <i>Manassas, Va.</i>			
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.		25a. REC'D BY REG STAR DATE <i>DEC 20 1967</i>	25b. REGISTRAR'S SIGNATURE <i>John G. Ball</i>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Go to pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3 Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial manifest sheet. File pages 1 and 2 with the State Health Department of Maryland prior to burial, demolition, or removal, and in any event within 72 hours after death.

Items 18&21 Film 396
1-15-68 ams MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17177

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS Rt. 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle Edwin	Last Combs	4. DATE OF DEATH 12	Month 30	Day 19	Year 67
5. SEX Male	6. COLOR OR RACE White	7. MARRIED X	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 06/18/11	9. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Combs		14. MOTHER'S MAIDEN NAME Rebecca Cain					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 236-14-6877		17. INFORMANT Harold Combs		Address 2308 Pleasant View Court, Ellicott City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4201		DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause { b) Arteriosclerotic heart disease c) Hypertension; Chronic Ethylism		Acute coronary insufficiency due to		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension; Chronic Ethylism							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect' on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED DEC. 31, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		23b. DATE THEREOF 1-4-68		23c. NAME OF CEMETERY OR CREMATORIAL Cood She Phred		23d. LOCATION (City or Town) Ellicott City Howard Md.	
23e. BURIAL CREMATION, REMOVAL (Specify) Burial		23f. ADDRESS Hughesbottom-Stack		23g. REC'D. BY REGISTRAR JAN 3 1968		23h. REGISTRAR'S SIGNATURE Charles J. ...	
24. FUNERAL DIRECTOR Hughesbottom-Stack		ADDRESS Ellicott City, Md.		25a. DATE John R. Shanks		25b. REGISTRAR'S SIGNATURE	

b = v - w

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>19 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>10414 Lorain Avenue</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>10414 Lorain Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print)	First <i>Jack</i>	Middle <i>H.</i>	Last <i>Connelly</i>	4. DATE OF DEATH <i>12</i>	Month <i>7</i>	Day <i>1967</i>	Year	
S SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH <i>June 12, 1894</i>	9 AGE (In years lost birthday) <i>73 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Procurement Spec.</i>		10b KIND OF BUSINESS OR INDUSTRY <i>U. S. Government</i>		11 BIRTHPLACE (County & State, or foreign country) <i>Illinois</i>		12 CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>John H. Connelly</i>				14. MOTHER'S MAIDEN NAME <i>Cora M. Bickelhaupt</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>082-01-0094</i>		17. INFORMANT <i>A Greta L. Connelly</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Myelogenous Leukemia</i>		
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.		DUE TO <i>1991</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>2-1/2 yrs</i>		
		(b) DUE TO						
		(c) DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Coronary Artery Disease</i>								
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>9/25</i> , 19 <i>65</i> , to <i>12/12</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>12/16</i> , 19 <i>67</i> , and that death occurred of <i>3A</i> M, from causes and on the date stated above								
22a. SIGNATURE <i>G. Leonard Gold</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/17/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>G. Leonard Gold</i>		22d. ADDRESS <i>9801 Georgia Avenue, Silver Spring, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Dec. 7, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Port Lincoln Crematory</i>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <i>John B. Murphy, Inc.</i>		ADDRESS <i>8434 Georgia Ave.</i>		25a. REC'D BY REGISTRAR <i>Prince Georges Co. Md.</i>		25b. REGISTRAR'S SIGNATURE <i>R. Leonas Judge</i>		
20 M 1966		DATE <i>DEC 11 1967</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be used as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17183

CERTIFICATE OF DEATH

17179

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Wheaton

1 yr. 11 Mos.

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

12907 Goodhill Road

3. NAME OF
DECESSED
(Type or print)

Margaret

First Middle

E.

Conyngham

Last

4. DATE
OF
DEATH

December 7, 1967

Month

Day

Year

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

July 4, 1897

9. AGE (in years
last birthday)

70

yrs.

10. IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. JEWISH OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE County & State, or foreign country

Penna.

13. FATHER'S NAME

Michael Jordan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Son

William J. Conyngham

Address

Same as Item 2.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last

(b)

DUE TO

(c)

Cerebral thrombosis

Arteriosclerotic cardiovascular disease

Cerebrovascular accident

INTERVAL BETWEEN
ONSET AND DEATH

1961

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Diabetes

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a.m.

p.m.

19

20d. INJURY OCCURRED

While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

Feb. 9, 1961, to Dec. 7, 1967, that (I) (we) last saw the deceased alive on Oct. 27, 1967, and that death occurred at 7:50 AM, from the causes and on the date stated above.

22a. SIGNATURE

Raymond Bradshaw, Jr., MD

22b. DATE
SIGNED

Dec. 7, 1967

22c. PHYSICIAN'S
NAME (Type)

Raymond Bradshaw, Jr., MD

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

345 University Blvd., W., Silver Spring, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

12-11-67

23c. NAME OF CEMETERY OR CREMATORIUM

St. Mary's Cemetery

23d. LOCATION (City, town or county)

Hanover, Penna.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ROBERT A. PUMPHREY, Bethesda, Maryland

ADDRESS

25a. REC'D BY REGISTRAR

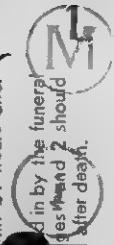
DATE

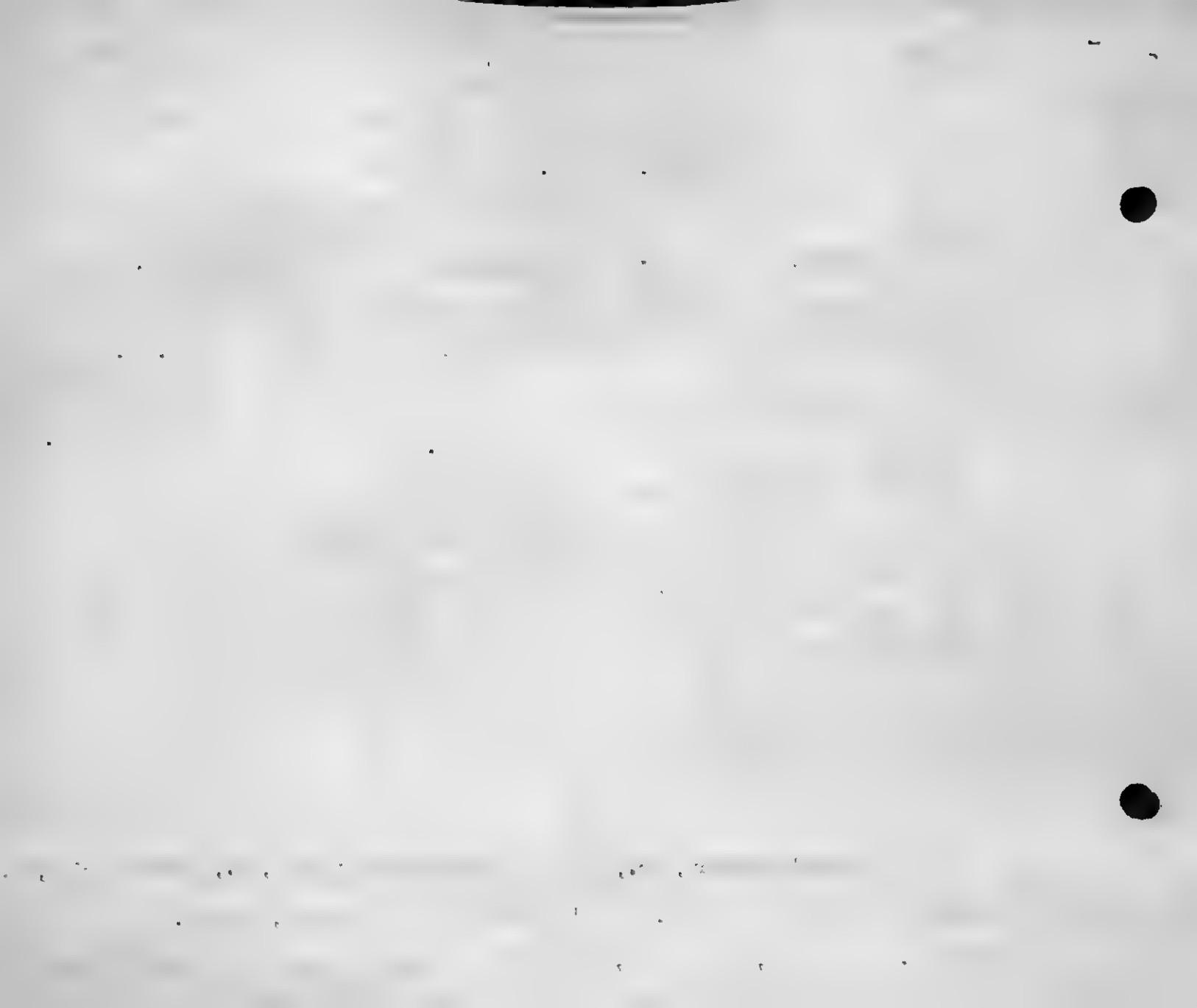
25b. REGISTRAR'S SIGNATURE

DEC 11 1967 Charles Judge

Cleared with medical examiner

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17180

1. PLACE OF DEATH a. COUNTY MONTGOMERY		Item #7 Film #1396 12/26/67		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 1 Mo - 9 Mth		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENSINGTON GARDENS		e. STREET ADDRESS 7204 MAPLE AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) OTHO COOLEY		First O	Middle B	Last COOLEY	4. DATE OF DEATH DEC. 12 - 1967
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 10-78	9. AGE (In years last birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MAINTENANCE MAN		11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY Co. Md. U.S.A.	
13. FATHER'S NAME RICHARD COOLEY		14. MOTHER'S MAIDEN NAME LOUISE AUSTIN		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 519-12-1291		17. INFORMANT Address Family of the deceased (same as above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-501 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Myocardial Infarction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11000 Old Georgetown Rd.	20f. (City or town) Rockville, Maryland	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-11, 1967 to 12-12, 1967 , that (I) (we) last saw the deceased alive on 12-11, 1967 , and that death occurred at 2:30 pm , from the causes and on the date stated above.				22b. DATE SIGNED 12-12-67	
22a. SIGNATURE Robert T. Thibadeau		22b. ADDRESS 11000 Old Georgetown Rd.		22c. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		22d. ADDRESS Rockville, Maryland		22e. DATE SIGNED 12-12-67	
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial Dec. 15, 1967		23b. DATE THEREOF Monocacy Cemetery	23c. NAME OF CEMETERY OR CREMATORIAL Monocacy Cemetery	23d. LOCATION (City, town or county) Beallsville Md	
24. FUNERAL DIRECTOR Arthur Walters		254. ADDRESS D.6 Carroll St	25a. REC'D BY REGISTRAR DEC 18 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	
VR AIS (4) 2DM 1/65		DATE DEC 18 1967			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 24 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 8 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. STREET ADDRESS Highland 20777	
3. NAME OF DECEASED (First Type or print) Joseph		4. DATE OF DEATH Last Month Day Year Cooney 12 23 1967	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED WIDOWED X		8. NEVER MARRIED DIVORCED □	
9. DATE OF BIRTH 9/28/06		10. AGE (In years last birthday) 61 yrs.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed-disabled		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Cooney		14. MOTHER'S MAIDEN NAME Mary A. French	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO	
17. INFORMANT Hospital Records,		Address Olney, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic congestive cardiac failure		2 years	
DUE TO (c) Cirrhosis of the liver		10 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Tobacco pneumonia, rt lower lung		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 67 , to 12/23/ , 19 67 , that (I) (we) saw the deceased alive on 12/22 , 19 67 , and that death occurred at 3:23 PM from causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker		MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		22b. DATE SIGNED 12/24/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-27-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS UNION F/111-C.T.C.T.Y		23d. LOCATION (City or Town) (County) (State) Bethesda/Hlth Montg. Md	
24. FUNERAL DIRECTOR Higginbotham-Stack		25a. REC'D BY REG STRR DATE DEC 29 1967	
25b. REGISTRAR'S SIGNATURE W. Miles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-troupe Permit. Then please remove carbon paper Pages 1 and 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event within 72 hours after death.

17186		17182	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN LB <i>3 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE <i>Dist. of Columbia</i> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> d. STREET ADDRESS <i>3714 - Chesaapeake</i>	
3. NAME OF DECEASED First <i>Walter</i> Middle <i>Hunt</i> Last <i>Cottrell</i> (Type or print)		4. DATE OF DEATH Month <i>Dec.</i> Day <i>2</i> Year <i>1967</i>	
5. SEX <i>Male</i> 6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>1-14-86</i>		9. AGE (In years last birthday) <i>81 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wisman & Miller</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Government</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Colorado</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>-</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Tabor</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>578-62-2616</i>	
17. INFORMANT <i>Walter Hunt Cottrell</i>		Address <i>11509 Rockville Rd. Silver Spring, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Treatment</i> DUE TO (c) <i>Cancer of Larynx</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <i>Cancer of Prostate</i>		19. WAS AUTOPSY PERFORMED? <i>NO</i>	
20a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1953</i> to <i>Dec. 2, 1967</i> that (I) (we) last saw the deceased alive on <i>Dec. 2, 1967</i> , and that death occurred at <i>7:10 AM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>Dec. 3, 1967</i>	
22a. SIGNATURE <i>Robert N. Coale</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>4429 Bradley Lane Chevy Chase Md.</i>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT N. COALE</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE THEREOF <i>12-6-1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Parklawn Cemetery</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i> <i>5130 Wisconsin Ave. N.W. Wash. D.C.</i>		25a. RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE <i>DEC 5 1967</i> <i>Robert N. Coale</i>	



Cleared to Medical Examiner, L.S.

7187

MARYLAND STATE DEPARTMENT
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET
BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2, and file this certificate with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN lb DOA		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY PRINCE GEORGE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSP.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			
						d. STREET ADDRESS 7514 JACKSON AVE.			
3. NAME OF DECEASED (Type or print)		First IDA	Middle ANN	Last CRAFT	4. DATE OF DEATH 12 - 30	Month Year 1967	Day	Year	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-12-81	9. AGE (In years last birthday) 86 yrs	FUNDER 1 YEAR Months 12	IF UNDER 24 HRS. Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LESLIE D. COPEMAN		14. MOTHER'S MAIDEN NAME ANNIE BATCHLOR							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NONE		16. SOCIAL SECURITY NO NONE		17. INFORMANT DR. EVELYN GREER - SAME		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Congestive heart disease (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		21. I certify that (I) (this hospital) attended the deceased from 1953 , 19 to 1967 , 19 that (I) (we) last saw the deceased alive on 1965 , and that death occurred at 7514 Jackson Ave., M. from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. M.D. AT CERTIFICATION		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 401 Park Rd. Silver Spring, MD	(County) MD	(State) MD	22b. DATE SIGNED 4/1/87	
22c. SIGNATURE Nash McClinton		22d. ADDRESS 401 Park Rd. Silver Spring, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Jan. 4, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery		23d. LOCATION Warner E. Pumphrey, Inc. Silver Spring, MD.		25a. REC'D BY REGISTRAR NR		25b. REC'D BY CLERK NR



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17188

CERTIFICATE OF DEATH

17186

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it must be detached for use as the burial transit permit. Then please remove carbon paper. **Page 3** should be retained by the funeral director. **Page 3** should be detached for use as the burial transit permit. Then please remove carbon paper. **Page 3** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE	
<i>Montgomery</i> <i>Maryland</i>		<i>Maryland</i> <i>Bethesda</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN b. <i>9 hours</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. STREET ADDRESS <i>5003 Alta Vista Rd</i>	
3 NAME OF DECEASED (Type or print) <i>Broz F. Cypres</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
S SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH <i>9-6-03</i>		9 AGE (In years last birthday) <i>64 yrs</i>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13 FATHER'S NAME <i>William</i>		14 MOTHER'S MARRIED NAME <i>Lena N. Hall</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO	
17 INFORMANT <i>Wabond - Leonard Cypres</i>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Advanced coronary arteriosclerosis</i> (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Thrombosis, right femoral artery; Thrombo-endo-arterectomy, 5hrs post-surg.</i>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18) <i>While at work</i>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>JAN 5, 1966</i> to <i>DEC 18, 1967</i> , that (I) (we) last saw the deceased alive on <i>DEC 18, 1967</i> , and that death occurred at <i>10:30 AM</i> from causes and on the date stated above		22b DATE SIGNED <i>DEC 18, 1967</i>	
22c PHYSICIAN'S NAME (Type) <i>G. Brown Tolson</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d ADDRESS <i>THOMAS F. O'CONNOR</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>12-21-67</i>	
23c NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Gem.</i>		23d LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a RECEIVED BY REGISTRAR <i>DEC 26 1967</i>	
		25b REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 396 MARYLAND STATE DEPARTMENT OF HEALTH
12-29-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										17187	
1 PLACE OF DEATH a. COUNTY MONT.					2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) b. STATE WASHINGTON D.C. COUNTY Prince Georges						
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK					d. LENGTH OF STAY IN 1b (3) 3 days						
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN & Hospital 5429 MARLBOROUGH PIKE					f. STREET ADDRESS 16-2						
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3 NAME OF DECEASED (Type or print)		First KENNETH	Middle William	Surname Cummings	4 DATE OF DEATH		Month 12	Day 16	Year 67		
5 SEX M		6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8 DATE OF BIRTH 9-23-1903	9 AGE (in years last birthday) 64 yrs		10 IF UNDER 1 YEAR Months 0		11 IF UNDER 24 HRS Days 0		
10a. JEWISH OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) VA.		12 CITIZEN OF WHAT COUNTRY? USA.					
13. FATHER'S NAME WALTER Cummings		14. MOTHER'S MAIDEN NAME MARTHA CORDELL									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 223-18-4833		17. INFORMANT HOSPITAL Record		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201		DUE TO Acute myocardial infarction;				INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary artery heart disease		(b) DUE TO Coronary artery heart disease		(c)							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED DEC. 16, 1967					
EXAMINER'S NAME (Type) BELDEN R. REAP		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (if applicable, county) Hutchinson Funeral Home									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 19, 1967		23c. NAME OF CEMETERY OR CREMATORIUM St James Episcopal Cemetery		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR Hutchinson Funeral Home		ADDRESS 1401 Carrollton Avenue		25a. REC'D BY REG STRAR Charles Judge		25b. REG STRAR'S SIGNATURE Charles Judge					
				DATE DEC 20 1967							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 9 Film 390 12/13 KK

CERTIFICATE OF DEATH

17188

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) g. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b e. STREET ADDRESS Holy Cross 2532 ROSS Rd., Apt 101	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year Dec 17 1967	
S SEX F	6. COLOR OR RACE N	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cafeteria mgr		9. AGE (In years lost birthday) 51 yrs	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME George Gennis		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Frank Cunningham, husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. 4-201		Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH —	
(b) DUE TO		Coronary Thrombosis —	
(c) DUE TO		Hypertensive Arterio Sclerotic Heart Disease —	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 1963, to 12/17, 1967 that (I) (we) last saw the deceased alive on 12/17/1967 and that death occurred at 9:02 M, from causes and on the date stated above.		22b. DATE SIGNED 12/18/67	
22c. PHYSICIAN'S NAME (Type)		M.O. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22d. ADDRESS Lawrence D. Marcus		22d. ADDRESS 1111 SPRING STREET, S.S.U.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/21/1967	
23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR John R. Fisher		ADDRESS 1432 - 1st St. N.W. REC'D BY REGISTRAR APR 27 1967	
		25b. REGISTRAR'S SIGNATURE John R. Fisher	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17189

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 1 day		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hospital		e. STREET ADDRESS 3708 East West Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Hobson Deibler		First David	Middle Hobson	Last Deibler	4. DATE OF DEATH December 30 1967
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-98	9. AGE (in years last birthday) 69 yrs.	F. UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer - Retired		10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME David P. Deibler		14. MOTHER'S MAIDEN NAME Emma Huntzberger		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-36-9900	17. INFORMANT Hosp. Records	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebral vascular Disease (CVA)				INTERVAL BETWEEN ONSET AND DEATH 11 hours	
(b) DUE TO DUE TO Arteriosclerotic Heart Disease - Coronary Thrombosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND'T ON GIVEN IN PART I(a) Aortic lymphatic Leukemia - diabetes mellitus.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Dec 30, 1967	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/30/67 , 1967, to Dec 30 , 1967, that (I) (we) last saw the deceased alive on Dec 30 , 1967, and that death occurred at 1:40 PM , from causes and on the date stated above.					
22a. SIGNATURE Aaron H. Traum		MD <input type="checkbox"/>	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED Dec 30, 1967	
22c. PHYSICIAN'S NAME (Type) Aaron H. Traum, M.D.		22d. ADDRESS 8237 Georgia Ave Silver Spring Montgomery Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/68	23c. NAME OF CEMETERY OR CREMATORIAL Congressional Cemetery	23d. LOCATION (City or Town) Washington, D.C.	(County) (State)
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Washington, D.C.		ADDRESS	25a. REC'D BY REGISTRAR JAN 5 1968	25b. REGISTRAR'S SIGNATURE Charles J. Traum	

executed within 24 hours after death.

low requires that

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH							
1 PLACE OF DEATH a. COUNTY Montgomery				2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE District of Columbia			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN 1b 19 Days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d STREET ADDRESS 11 Starboard Green	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Mariano		First Mariano	Middle Delmundo	Lost	4. DATE OF DEATH December 31	Month 1967	Day 19
S. SEX Male	6. COLOR OR RACE Malayan	7. MARRIED X NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1924	9. AGE (In years last birthday) 43 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Imus Cavite, P.I.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Petronilo Delmundo				14. MOTHER'S MAIDEN NAME Antonia Samson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) 1946-1967		16. SOCIAL SECURITY NO. 575-32-4201		17. INFORMANT 11 STARBOARD GREEN Mrs. Basilia Delmundo S.W. Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Duodenal Ulcer with Perforation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO last (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 12 , 19 67 , to Dec 31 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 31 , 19 67 , and that death occurred at 7:00 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>W.R. Hix</i>		M.D. ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED Jan 1, 1968	
22c. PHYSICIAN'S NAME (Type) W.R. HIX, M. D.		22d. ADDRESS Naval Hospital Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/5/68		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va	
24. FUNERAL DIRECTOR Falls Church Funeral Home, Falls Church, Va.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>	
DATE JAN 8 1968							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Washington D.C.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>3412 Quince St NW</i>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3 NAME OF DECEASED (Type or print) <i>Theodore North Denslow</i>		First	Middle					
4 DATE OF DEATH Lost <input type="checkbox"/> DEC. 24 1967		Month	Doy Year					
5 SEX <i>Male</i>		6 COLOR OR RACE <i>Caucasian</i>	7 MARRIED WIDOWED <input type="checkbox"/>	8. NEVER MARRIED <input type="checkbox"/>	9. DATE OF BIRTH <i>7/4/82</i>	10. AGE (In years last birthday) <i>85 yrs</i>	11. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	12. IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>(RETIRED) Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Public Schools</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Vermont</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Herbert M. Denslow</i>		14. MOTHER'S MAIDEN NAME <i>Anna M. Olmstead</i>		15. INFORMANT <i>Josephine Denslow - 3412 Quince St NW</i>		Address <i>Wash D.C.</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH <i>7/22/67</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>491X</i>		DUE TO <i>Bronchopneumonia</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i>		DUE TO (c) <i></i>						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic Cardiovascular Disease</i>								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i></i>						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>OCTOBER 1, 1967</i> , to <i>12/24, 1967</i> , that (I) (we) last saw the deceased alive on <i>12/23, 1967</i> , and that death occurred at <i>12/24 M</i> , from causes and on the date stated above.								
22a. SIGNATURE <i>G. Leonard Gold</i>		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>12/24/67</i>				
22c. PHYSICIAN'S NAME (Type) <i>G. Leonard Gold, M.D.</i>		22d. ADDRESS <i>8641 Colesville Road, Silver Spring Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>12/26/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>F. L. Livenen Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Columbia Mortuary, Silver Spring, Md.</i>		
24. FUNERAL DIRECTOR <i>H. H. CHAMBERS Co.</i>		25a. ADDRESS <i>8665 Georgia Ave, Silver Spring Md.</i>		25b. RECD BY REGISTRAR DATE <i>DEC 29 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>		



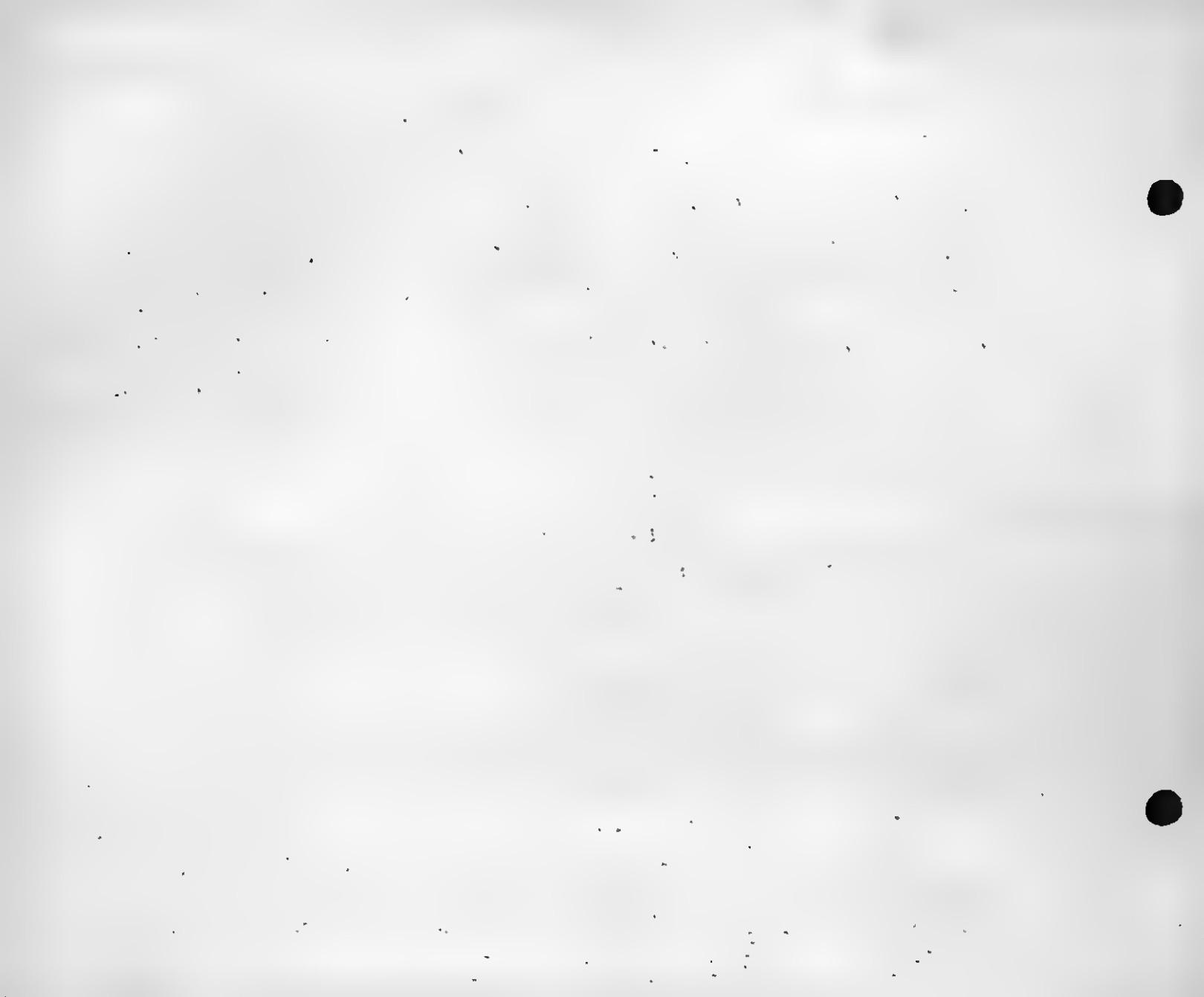
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 8:30 PM
MARGARET EDITH DONNELLY						Dec. 27 1967	
3. SEX F		4 RACE Caucasian	5. DATE OF BIRTH 12-23-1880		6. AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH WHEATON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNIVERSITY NURSING Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MD		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 407 MANSFIELD RD		
14. FATHER'S NAME Julius Frederick WALTERS			15. MOTHER'S MAIDEN NAME JULIA CHRISTINA-SCHMELZ				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 219-54-9858		17. INFORMANT George Donnelly	Address 407 Mansfield Rd., Silver Spring, Md.	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) General debility DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause (c) Asbestosis .							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Malnutrition							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Aug. 24, 1967 , to Dec. 27, 1967 , that (I) (we) last saw the deceased alive on Dec. 24, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Russell C. Bufalino, M.D.							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Russell C. Bufalino, M.D., 1429 University Blvd. W. S.S., Md.		22c. DATE SIGNED Dec. 27, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 27, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Westminster Cemetery		23d. LOCATION (City or Town) Bala Cynwyd, Pennsylvania		(County) (State)
24. FUNERAL DIRECTOR Charles J. Donnelly		24b. ADDRESS Silver Spring, Md.		25a. REC'D BY REGISTRAR Jan 8, 1968		25b. REGISTRAR'S SIGNATURE Charles J. Donnelly	



MARYLAND STATE DEPARTMENT OF HEALTH
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1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>15 Hrs-35 min</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Barrett Park</i>	
d. STREET ADDRESS <i>4711 Oxford St.</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>William J.</i>	FIRST <i>William</i>	MIDDLE <i>J.</i>	LAST <i>Dove</i>
4 DATE OF DEATH <i>Dec 8 1967</i>	Month <i>Dec</i>	Day <i>8</i>	Year <i>1967</i>
S SEX <i>Male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>1/30/90</i>		AGE (in years last birthday) <i>17 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Businessman and financial advisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Park</i>	
11. BIRTHPLACE (County & State, or for e.g., country) <i>Montgomery County, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>John Dove</i>		14. MOTHER'S MAIDEN NAME <i>Milner</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO. <i>312-12-5813</i>	
17. INFORMANT <i>John Dove</i>		Address <i>4711 Oxford St., Rockville, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Agute Cardiogenic Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>29 days</i>	
DUE TO (b) DUE TO (c) <i>Broncho pneumonia</i>		4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Bronchitis - Emphysema</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>Dec 5 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>Rockville</i>		(County) (State) <i>Montgomery Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 5 1967</i> to <i>Dec 8 1967</i> that (I) (we) last saw the deceased alive on <i>Dec 7 1967</i> , and that death occurred at <i>12:45 PM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>12-8-67</i>	
22a. SIGNATURE <i>Robert T. Thibadeau</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS <i>11000 Old Georgetown Rd Rockville</i>
22c. PHYSICIAN'S NAME (Type) <i>ROBERT T. THIBADEAU</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/11/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parkland Cemetery</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		ADDRESS <i>1551 Rock Pike Rockville, Md.</i>	25a. REC'D BY REGISTRAR DATE DEC 11 1967 25b. REGISTRAR'S SIGNATURE <i>Charles J. Tyson</i>



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and send the death certificate to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

CERTIFICATE OF DEATH

17194

1 PLACE OF DEATH a COUNTY MONTGOMERY			2 USUAL RESIDENCE (Where deceased lived, if institut. or Residence before admission) a STATE MARYLAND		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		
c LENGTH OF STAY IN 16 2 mos.			d STREET ADDRESS 609 Coist Ave.		
8 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. SAN. & Hosp.			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)		First ELIZABETH	Middle CORACE	Lost POWNEY	4 DATE OF DEATH DEC. 28 1967
5 SEX F		6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-27-82	9. AGE (In years lost birthday) 85 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.S.W.F.			10b KIND OF BUSINESS OR INDUSTRY Own home		12 CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME CHARLES VOSS			14. MOTHER'S MAIDEN NAME ERINIE RYER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —			16. SOCIAL SECURITY NO 219 52-5444		17. INFORMANT Charl. Voss
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Inherited athritis			INTERVAL BETWEEN ONSET AND DEATH yr		
DUE TO (b) Fractured leg			DUE TO (c)		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) Montgomery	(County) Maryland
21. I certify that (I) (this hospital) attended the deceased from 1/15/67 , to 1/28/67 , 1967, that (I) (we) last saw the deceased alive on 1/17/67 , 1967, and that death occurred at 720 M , from causes and on the date stated above.					
22a. SIGNATURE John H. Stotherton			22b. DATE SIGNED 1/20/67		
22c. PHYSICIAN'S NAME (Type) Chas. H. W. L. H. W.			22d. ADDRESS 740 Blk Rd NW Wash DC		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 30, 1967	23c. NAME OF CEMETERY OR CREMATORIAL St. Louis Cemetery	23d. LOCATION (City or Town) Montgomery, Maryland	
24. FUNERAL DIRECTOR Baron E. Johnson		ADDRESS 1001 18th Street, N.W., Washington, D.C.		25a. REC'D BY REGISTRAR JAN 2 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17197

CERTIFICATE OF DEATH

17195

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital Bethesda			d STREET ADDRESS 8413 Gibbons Drive		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print)	First BRIAN	Middle KEITH	Last DOYLE	4. DATE OF DEATH December 1 1967	Month Day Year
5 SEX male	6 COLOR OR RACE cauc	7 MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 14 Nov 1967	9 AGE (In years last birthday) yrs 0 14	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Andrews Air Force Base	
13 FATHER'S NAME Thomas A. Doyle			14. MOTHER'S MAIDEN NAME Martha B. Blanchard		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO NONE	17 INFORMANT Father 8413 Gibbons Dr.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGENITAL HEART DEFECT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ (c) _____ DUE TO (d) _____ (e) _____ (f) _____ (g) _____ (h) _____ (i) _____ (j) _____ (k) _____ (l) _____ (m) _____ (n) _____ (o) _____ (p) _____ (q) _____ (r) _____ (s) _____ (t) _____ (u) _____ (v) _____ (w) _____ (x) _____ (y) _____ (z) _____ (aa) _____ (bb) _____ (cc) _____ (dd) _____ (ee) _____ (ff) _____ (gg) _____ (hh) _____ (ii) _____ (jj) _____ (kk) _____ (ll) _____ (mm) _____ (nn) _____ (oo) _____ (pp) _____ (qq) _____ (rr) _____ (ss) _____ (tt) _____ (uu) _____ (vv) _____ (ww) _____ (xx) _____ (yy) _____ (zz) _____ (aa) _____ (bb) _____ (cc) _____ (dd) _____ (ee) _____ (ff) _____ (gg) _____ (hh) _____ (ii) _____ (jj) _____ (kk) _____ (ll) _____ (mm) _____ (nn) _____ (oo) _____ (pp) _____ (qq) _____ (rr) _____ (ss) _____ (tt) _____ (uu) _____ (vv) _____ (ww) _____ (xx) _____ (yy) _____ (zz) _____ (aa) _____ 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MARYLAND STATE DEPARTMENT OF HEALTH

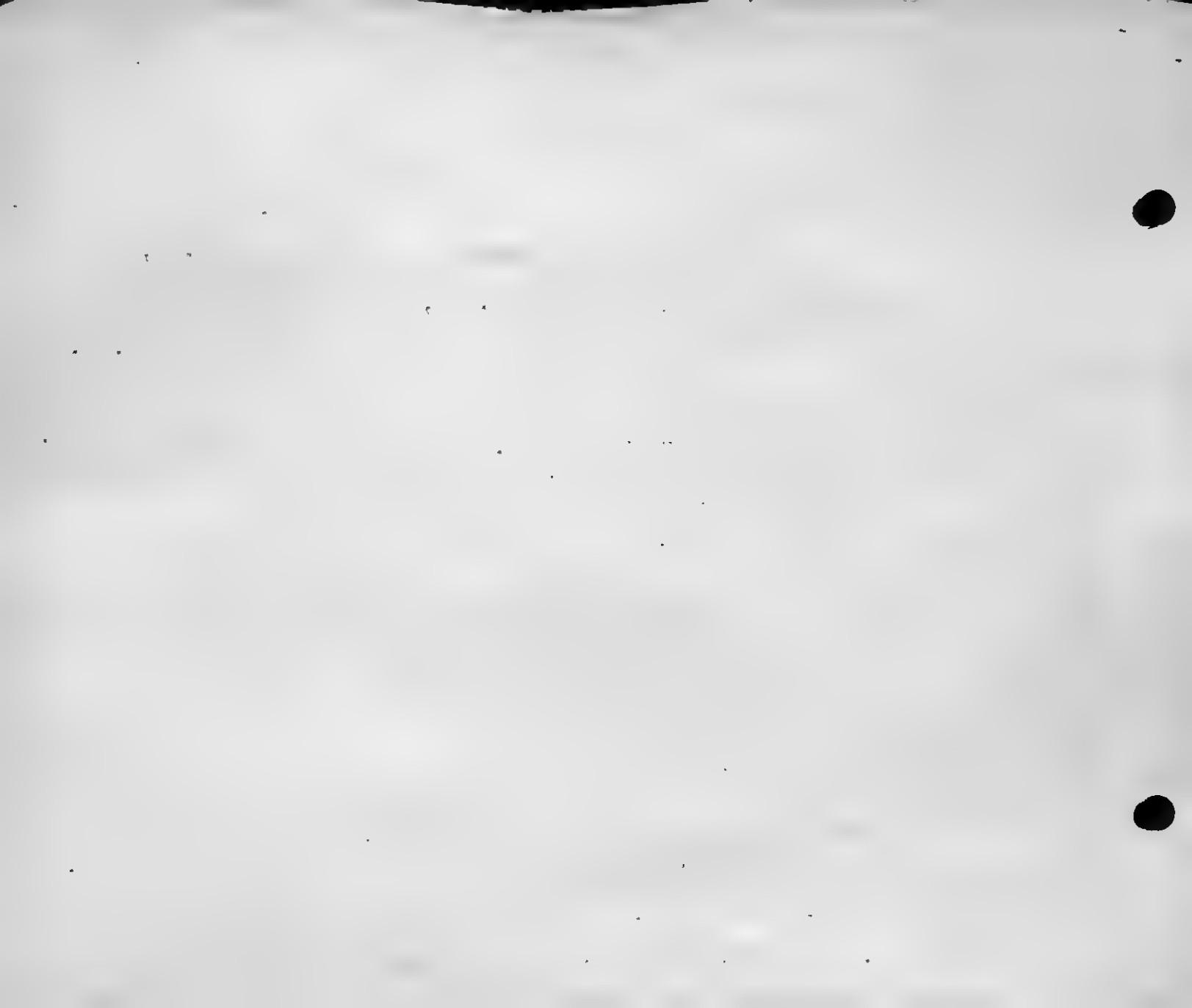
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17138

17196

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3204 Parkview Road		d. STREET ADDRESS 3204 Parkview Rd.			
3. NAME OF DECEASED (Type or print) NORA		4. DATE OF DEATH Last Month Day Year DUFFY Dec. 5, 1967			
5. SEX Female White		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 10, 1884	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Ireland	
13. FATHER'S NAME Patrick Ryan		14. MOTHER'S MAIDEN NAME Mary Walsh		12. CITIZEN OF WHAT COUNTRY U. S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No (Yes, no, or unknown) (If yes give war or date of service)		16. SOCIAL SECURITY NO. 142-38-3130		17. INFORMANT Daughter Mrs. Stephen Timko	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address Same as Item 2.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Cerebral Thrombosis arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 days ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... 1967 to 5 Dec., 1967 that (I) (we) last saw the deceased alive on... 3 Dec., 1967, and that death occurred at 1/15/67 from the causes and on the date stated above.					
22a. SIGNATURE William D. Aug		22b. DATE SIGNED 12/5/67			
22c. PHYSICIAN'S NAME (Type) WILLIAM D. AUG		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS () - 9006 Colesville Rd. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-67		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery	
24 FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DEC 7 1967	
				25b. REGISTRAR'S SIGNATURE Charles J. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17197

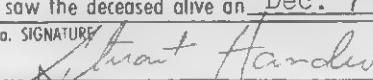
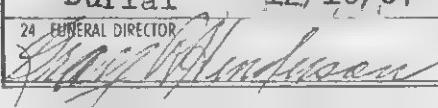
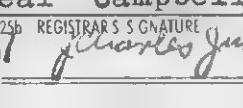
1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>805 Accola Ave.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>805 Accola Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>JACOB</i>	Middle	Last Month Day Year <i>Dukoff 12 4 1967</i>
4. SEX <i>MALE</i>	5. COLOR OR RACE <i>W</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>1/2/1923</i>
8. AGE (In years last birthday) <i>74 yrs.</i>	9. IF UNDER 1 YEAR Months Days Hours Min. <i>100 N. Belvedere Rd</i>	10. IF UNDER 24 HRS. Months Days Hours Min. <i>Bernard Kufman Silver Spring, MD</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Russia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Herschel Dukoff</i>	14. MOTHER'S MAIDEN NAME <i>Rachael Polisar</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>087-01-5007</i>	17. INFORMANT <i>Bernard Kufman</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Ca of the Bladder & Urinary obstruction	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>accvd</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1929 Univ. Blvd.</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11/23/1967</i> to <i>12/4/1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 4 1967</i> , and that death occurred at <i>5pm</i> M, from the causes and on the date stated above.		22b. DATE SIGNED <i>Dec 5, 1967</i>	
22a. SIGNATURE <i>Russell G. Bufalino</i>	22c. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <i>Russell G. Bufalino, M.D.</i>	22d. ADDRESS <i>1929 Univ. Blvd.</i>	
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-6-67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>GEO. L. VASH, Cem.</i>	23d. LOCATION (City, town or county) (State) <i>HATFIELD MD</i>
24. FUNERAL DIRECTOR <i>Conococheague Home</i>	ADDRESS <i>42179 Hwy 50. U.C.</i>	25a. REC'D BY REGISTRAR DATE <i>NFC 8 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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CERTIFICATE OF DEATH							
17200				17198			
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b. 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d. STREET ADDRESS 6928 Ruskin Street			
3. NAME OF DECEASED (Type or print) First Middle		Gary Eugene		4. DATE OF DEATH Dunaway December 7 1967		e. IS RESIDENCE ON A FARM? YES NO X	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DIVORCED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 31 March 1961		9. AGE (In years last birthday) 6 yrs	10. UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (County & State or foreign country) Washington, D.C.	
13. FATHER'S NAME Walter J. Dunaway				14. MOTHER'S MAIDEN NAME Christine Saunders			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record				<small>Address</small> The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Hypoxia				INTERVAL BETWEEN ONSET AND DEATH 3 hours			
<small>110</small> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Bronchopneumonia				3 Weeks			
(c) Cystic Fibrosis of the Pancreas				6 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While Not While of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 22, 1967 , to Dec. 7, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 7, 1967 , and that death occurred at 6:18 M. from causes and on the date stated above.							
22a. SIGNATURE 				P.M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR STAFF PHYS. <input checked="" type="checkbox"/> 12/8/67			
22b. DATE SIGNED 12/8/67							
22c. PHYSICIAN'S NAME (Type) Stuart Handwerger, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Check) Burial <input checked="" type="checkbox"/>		23c. NAME OF CEMETERY OR CREMATORIAL 12/10/67 Falling River Church		23d. LOCATION (City or Town) Brookneal, Va.		(County) (State)	
24. FUNERAL DIRECTOR 		ADDRESS Brookneal, Va.		25a. RECEIVED BY REGISTRAR DA. DEC. 13 1967		25b. REGISTRAR'S SIGNATURE 	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

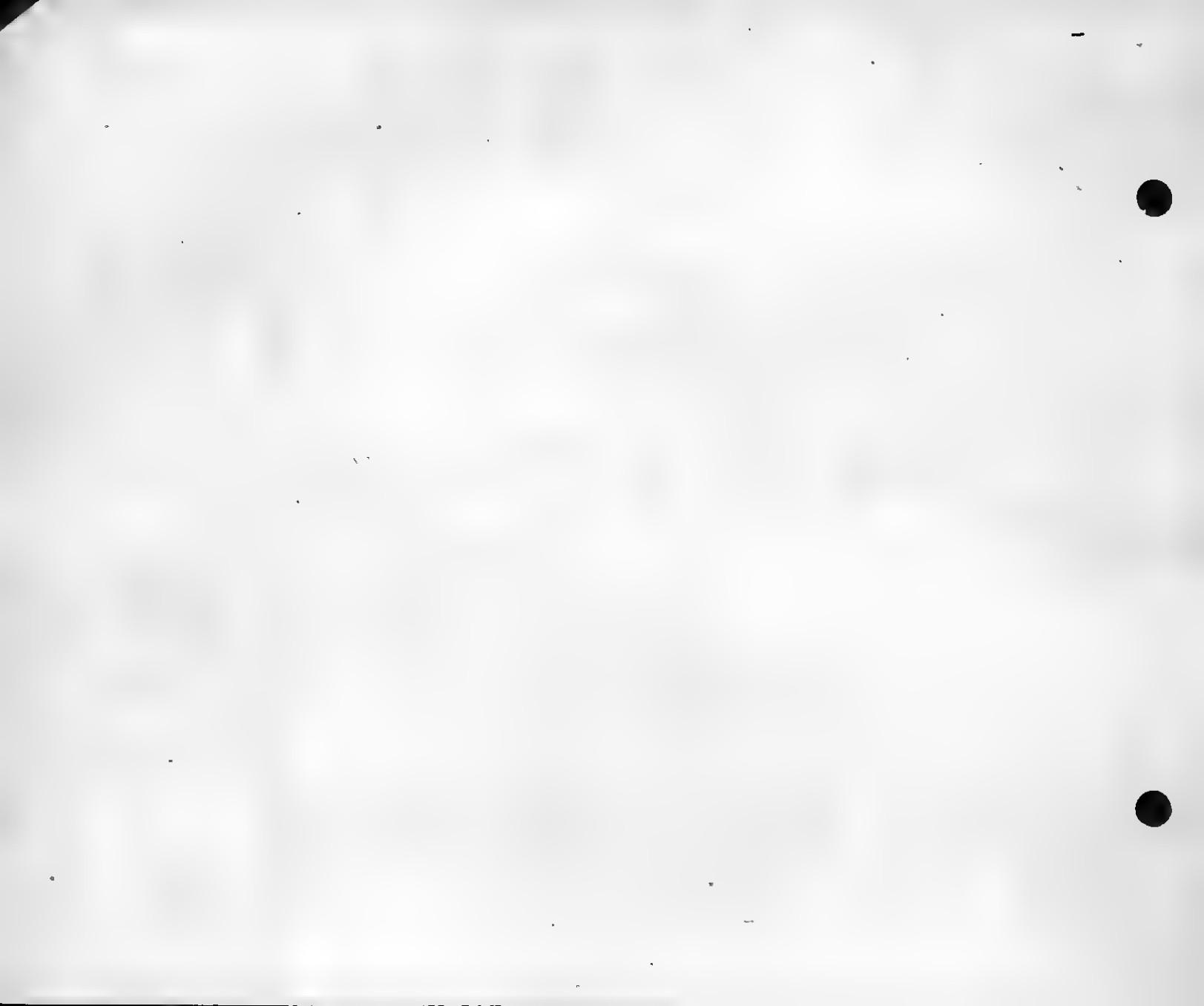
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17199

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>	c. LENGTH OF STAY IN 1b <i>8 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	d. STREET ADDRESS <i>6015 Massachusetts Ave</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>6015 Massachusetts Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Naomi</i>	First <i>S.</i>	Middle <i>Dunmen.</i>	4. DATE OF DEATH Month <i>Dec.</i> Day <i>24,</i> Year <i>1967</i>
5. SEX <i>f-</i>	6. COLOR OR RACE <i>w.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 11, 1888</i> 9. AGE (In years last birthday) <i>79 yrs.</i> IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Arkansas.</i>
13. FATHER'S NAME <i>William Jennings</i>		14. MOTHER'S MAIDEN NAME <i>Dora Green</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO <i>578 68 9820</i>	17. INFORMANT <i>Olin E Teague Daughter</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Insufficiency. Acute.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i>	
Conditions, if any, which gave rise to immediate cause (a). Stating the underlying cause last. <i>(b)</i>		DUE TO <i>(c)</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>12/24/67.</i>	
ACTUAL SIGNATURE <i>John G. Ball</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-29-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet</i>	23d. LOCATION (City or Town) (County) (State) <i>Fort Worth Texas</i>
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>	ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>	25a. REC'D BY REGISTRAR <i>DEC 29 1967</i>	25b. REGISTRAR'S SIGNATURE



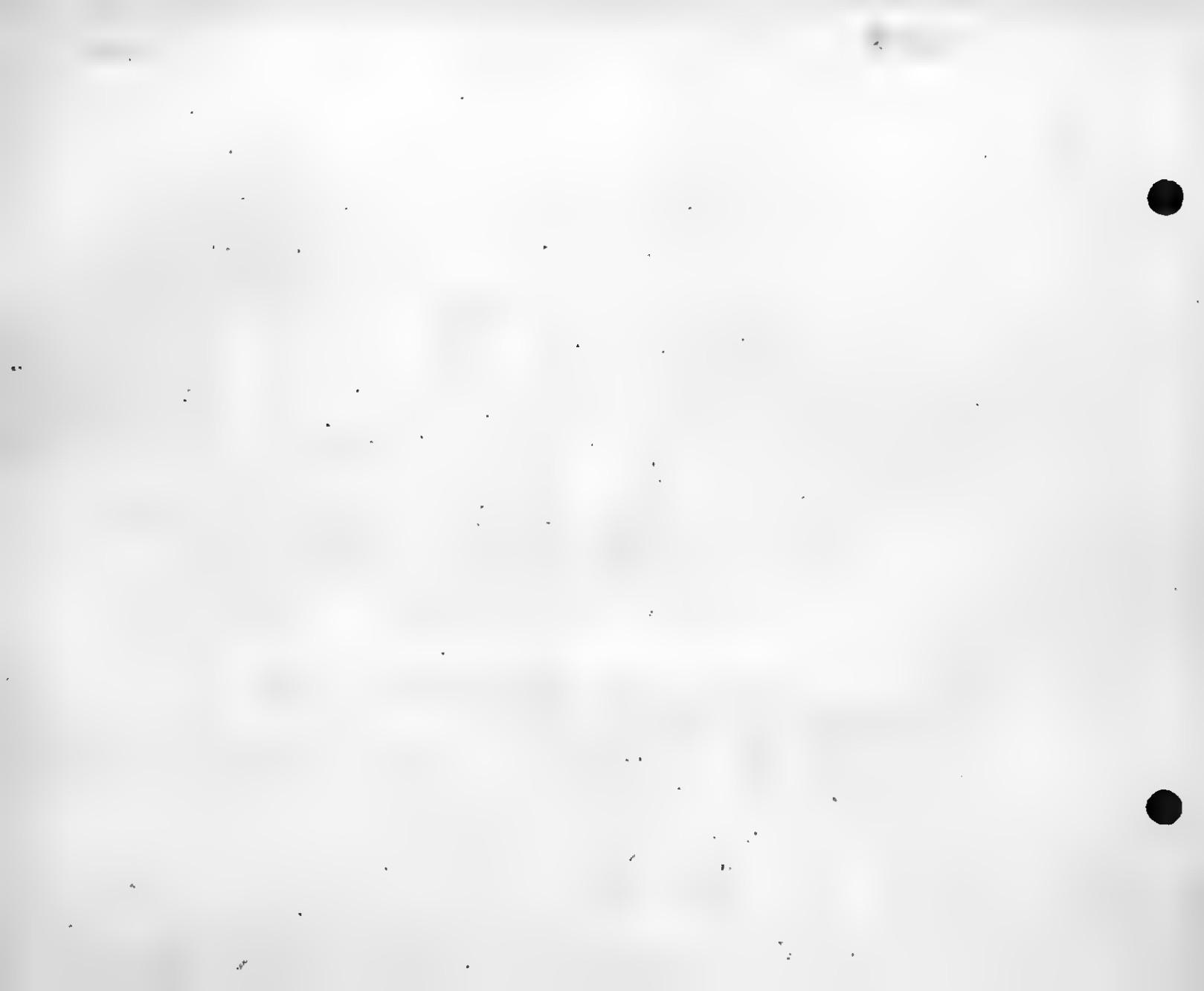
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)		First Thomas	Middle A.	Last Dunnington	2a. DATE OF DEATH Month Dec.	Day 30	Year 1967	2b. HOUR 3 P.M.
3. SEX Male		4 RACE White		S. DATE OF BIRTH 5-3-16	6 AGE (In years last birthday) 51 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Nash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10419 Lorain Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Government Contract		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13c. CITY OR TOWN Montgomery Sil.Spr.		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 10419 Lorain Ave.			
14. FATHER'S NAME First G.		Middle Howard	Last Dunnington	15. MOTHER'S MAIDEN NAME First Mary H. Miller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 577-05-1176		17. INFORMANT Mrs. Frances F. Dunnington		Address Same as		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction		4201		DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate		
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Mon Day 19 Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	
						State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 67 , to 12/30, 1967 , that (I) (we) last saw the deceased alive on 12/19/1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE A. F. Thibadeau MD		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12/30/1967		
22d. PHYSICIAN'S NAME (Type) A. F. THIBADEAU		22e. ADDRESS 10111 Colesville Rd. SIL. SP. MD.						
23a. BURIAL, CREMATION, BURIAL (Specify) BURIAL		23b. DATE 1-3-68	23c. NAME OF CEMETERY OR CREMATORIUM ST. JOHN'S CEMETERY		23d. LOCATION (City or Town) FOREST GLEN, MONT.		(County) MD.	
24. FUNERAL DIRECTOR FRANCIS J. COLLINS		ADDRESS 3821 14th ST. N.W.			25a. REC'D. BY REGISTRAR DATE JAN 5 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1 <i>7203</i>		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17201						
1 PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission)																
a COUNTY <i>Montgomery</i>		a STATE <i>Maryland</i>																
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		b COUNTY <i>Montgomery</i>																
c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits, write RJRAT and give nearest town) <i>Kensington</i>																
1 HR 50 MIN																		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		d STREET ADDRESS <i>Kensington Gardens Nursing Home</i>																
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																		
3 NAME OF DECEASED (Type or print) <i>Sally</i>		First <i>Sally</i>	Middle <i>MAY</i>	Last <i>Eaton</i>	4 DATE OF DEATH <i>Dec 23 1967</i>	Month <i>Dec</i>	Day <i>23</i>	Year <i>1967</i>	5 SEX <i>Female</i>		6 COLOR OR RACE <i>white</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>4/11/1878</i>	9 AGE (in years (on birthday) yrs <i>89</i>	10 IF UNDER 1 YEAR Months <i>0</i>	11 IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11 BIRTHPLACE (County & State, or foreign country) <i>Co Maryland (Baltimore)</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>												
13 FATHER'S NAME <i>Samuel Waddell</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Palmer</i>		15. ADDRESS <i>Elmwood Apartments 2221 Beale St., Philadelphia, PA</i>														
16. SOCIAL SECURITY NO. <i>814-54-0282</i>		17. INFORMANT <i>Son - Ralph Eaton, 2221 Beale St., Philadelphia, PA</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>acute pulmonary edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause list (b) <i>ASC VJ</i> DUE TO (c) <i>Diabetes mellitus</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>												
20a MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20c DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20d TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20e INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20g (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>dec 23 1967</i> , to <i>dec 23 1967</i> , that (s) (we) last saw the deceased alive on <i>23 Dec 1967</i> , and that death occurred at <i>at home</i> M, from causes and on the date stated above.				
22a SIGNATURE <i>Horace W. Bender, M.D.</i>		22b. DATE SIGNED <i>12/23/67</i>		22c. PHYSICIAN'S NAME (Type) <i>Dr. Fred W. Bender</i>		22d. ADDRESS <i>Horace W. Bender</i>												
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>12-26-67</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Faith United Chapel of Christ Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Charlottesville, Va., Md.</i>												
24. FUNERAL DIRECTOR <i>Raymond E. Creaghead</i>		25a ADDRESS <i>Crozier Funeral Home, Thurmont, Md.</i>		25b. REC'D. BY REGISTRAR DATE <i>DEC 27 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Raymond E. Creaghead</i>												



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
<i>Montgomery</i> Maryland		<i>Md.</i> <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>DoA</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <i>Wheaton</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sedgewick Hospital</i>		d. STREET ADDRESS <i>11409 Newport Mill Lane</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Melle</i>	Middle <i>E</i>	Last <i>Elmer</i>
4. DATE OF DEATH Month <i>Dec</i>	Day <i>6</i>	Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>9/8/1895</i>
9. AGE (In years last birthday) <i>72 yrs</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Retired Statistical Clerk Dept.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Nebraska</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Elmer K. Lingren</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO <i>578-46-5671-B</i>	17. INFORMANT <i>Roy A. Ebner</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>416X</i> DUE TO <i>Cardiac Arrest</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Rheumatic heart disease</i>	(b) DUE TO <i>60 years</i>	(c)	INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Nov 10 1967</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rockville, Maryland</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 10, 1967</i> , to <i>Dec 12/6, 1967</i> , that (I) (we) last saw the deceased alive on <i>August 4, 1967</i> , and that death occurred at <i>226 Rockville, Maryland</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Jack P. Segal</i>	22b. DATE SIGNED <i>12/6/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>Jack P. Segal</i>	22d. ADDRESS <i>5323 Conn Ave NW Washington DC</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Dec 9, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>	23d. LOCATION (City or Town) (County) (State)
23e. FUNERAL DIRECTOR <i>C. Glen Carter</i>	23f. ADDRESS <i>8434 Georgia Avenue</i>	23g. REC'D BY REGISTRAR <i>DEC 11 1967</i>	23h. REGISTRAR'S SIGNATURE <i>Glen Carter</i>
VR A15 (4) 25M 1/67			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17205

CERTIFICATE OF DEATH

17203

1. PLACE OF DEATH

a. COUNTY

Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring 16 yrs

c. LENGTH OF STAY IN lb

wrote RURAL and give nearest town)

Silver Spring 16 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

10611 Lockridge Drive

**3. NAME OF DECEASED
(Type or print)**

First Susan Middle

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Last

4. DATE OF DEATH

Month

Ellis

Day

Dec 15

Year

1967

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sales clerk

10b. KIND OF BUSINESS OR INDUSTRY

Retail

13. FATHER'S NAME

John W. Tilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

579 48 4812 Warren Ellis - Same Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

191.2

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

DUE TO

Probable Pulmonary Embolus

Abdominal Carcinomatosis

INTERVAL BETWEEN ONSET AND DEATH

hours

15 mos.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. 19 Not While at work

20d. INJURY OCCURRED While at work
Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 1966 to Dec 15, 1967, that (I) () last saw the deceased alive on Dec 11, 1967, and that death occurred at 7 A.M. from the causes and on the date stated above.

22a. SIGNATURE

James W. Egan

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED
December 15, 1967

22c. PHYSICIAN'S NAME (Type)

James W. Egan

22d. ADDRESS

5413 Cedar Lane - Bethesda

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Burial Dec 18, 1967 Arlington

Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

C. Carter

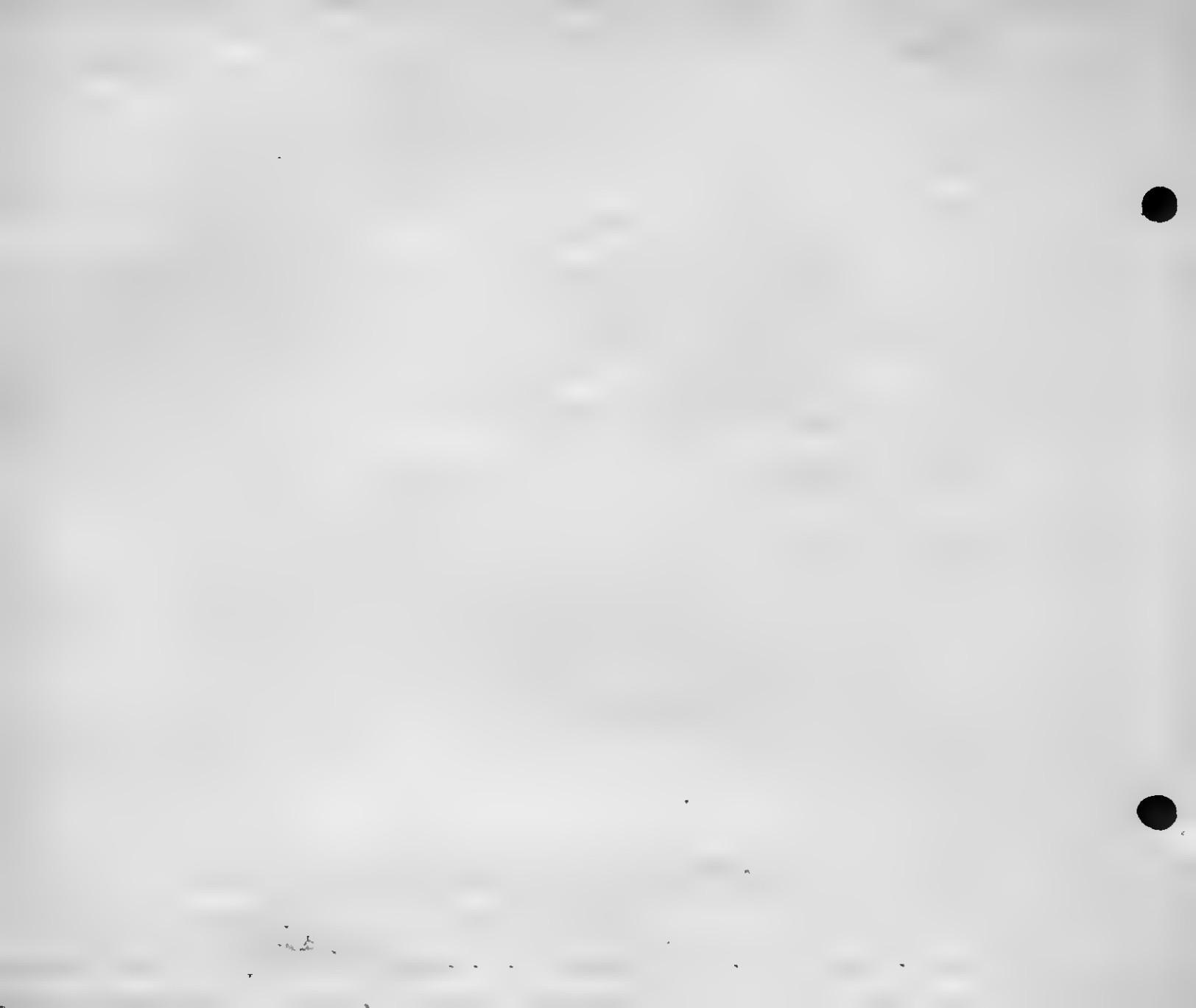
ADDRESS

Warner E. Pumphrey, Inc. 8434 Georgia Ave. S.S.

25a. REC'D BY REGISTRAR

DATE DEC 21 1967

REGISTRAR'S SIGNATURE
Judge



MEDICAL EXAMINER
NOTIFIED WILL APPROVE

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in at the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.17205 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17204

1. DECEASED-NAME (Type or print)	First SIMMA	Middle -	Last ELVOVÉ	2a. DATE OF DEATH Month 12	Day 31	Year 1967	2b. HOUR 8 P.M.
3. SEX FEMALE	4 RACE Cauc.	5. DATE OF BIRTH 10/20/1879			6. AGE (In years last birthday) 88	IF UNDER 1 YEAR MONTHS 18	IF JUNIOR 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH NEATON MD.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HORNIG UNIVERSITY NURSING	12a. USUAL OCCUPATION (Kind of work done during most of working-life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MD DC	13b. COUNTY D.C. & NW. WASH	13c. CITY OR TOWN N.W. WASH	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 4425 8TH ST. NW			
14 FATHER'S NAME First SCHOMER	Middle -	Last ELVOVE	15 MOTHER'S MAIDEN NAME First BARSHEVA	Middle -	Last BARSKY	Address	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 599-62-9649	17 INFORMANT ELIZABETH ELVOVE - Jamie HS '13	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus							
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this-hospital) attended the deceased from 11-24-1965 , to 12-31-1967 , that (I) (<input checked="" type="checkbox"/> we) lost saw the deceased alive on 11-28-1967 , and that in (my) (<input checked="" type="checkbox"/> our) opinion death occurred on the date and hour and from the causes stated above, (I) (<input checked="" type="checkbox"/> we) (<input type="checkbox"/> did) (<input checked="" type="checkbox"/> did not) view the body after death.							
22b. SIGNATURE Samuel A. Hillman MD	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 11/1/68			
22d. PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN	22e. ADDRESS 8829 FLOWER AVE SILVER SPRING MD 20901						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-2-1968	23c. NAME OF CEMETERY OR CREMATORIUM GEO WASH Cem. Inc.	23d. LOCATION (City or Town) HYATTSVILLE MD	(County)		(State)	
24. FUNERAL DIRECTOR Gooding Funeral Home 4217-9-Rec	ADDRESS 4217-9 Rec	25a. RECD BY REGISTRAR JAN	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2b, c & d

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institutional, residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>1 DAY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. 5 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH T. EVANS</u>		4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1967</u>	5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital Dining Service</u>		8. DATE OF BIRTH <u>March 22-1891</u>	9. AGE (In years last birthday) <u>76 yrs</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>JOHN WESLEY THOMPSON</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>212-32-1705A</u>	
17. INFORMANT <u>MRS Amy BEVAN HAURE DE GRANGE</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Arteriosclerotic Heart Disease</u> 4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>6 mos</u> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <u>3/67</u> to <u>12/16/67</u> , 19, that (I) (we) lost saw the deceased alive on <u>12/16/67</u> , and that death occurred <u>12/20/67</u> M, from causes and on the date stated above.		20f. (City or town) <u>Havre de Grace</u> (County) <u>Maryland</u> (State) <u>M.D.</u>	
22a. SIGNATURE <u>Henry C. Scruggs MD</u>		22b. DATE SIGNED <u>12/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry C. Scruggs MD</u>		22d. ADDRESS <u>5413 Cedar Lane Belvedere Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>ANNE HILL CEM.</u>
24. FUNERAL DIRECTOR <u>R. Madison Mitchell Havre de Grace Md</u>		23d. LOCATION (City or Town) <u>Havre de Grace</u> (County) <u>Maryland</u> (State) <u>M.D.</u>	
		25a. REC'D. BY REGISTRAR <u>J. Madison Mitchell</u>	25b. REGISTRAR'S SIGNATURE <u>J. Madison Mitchell</u>

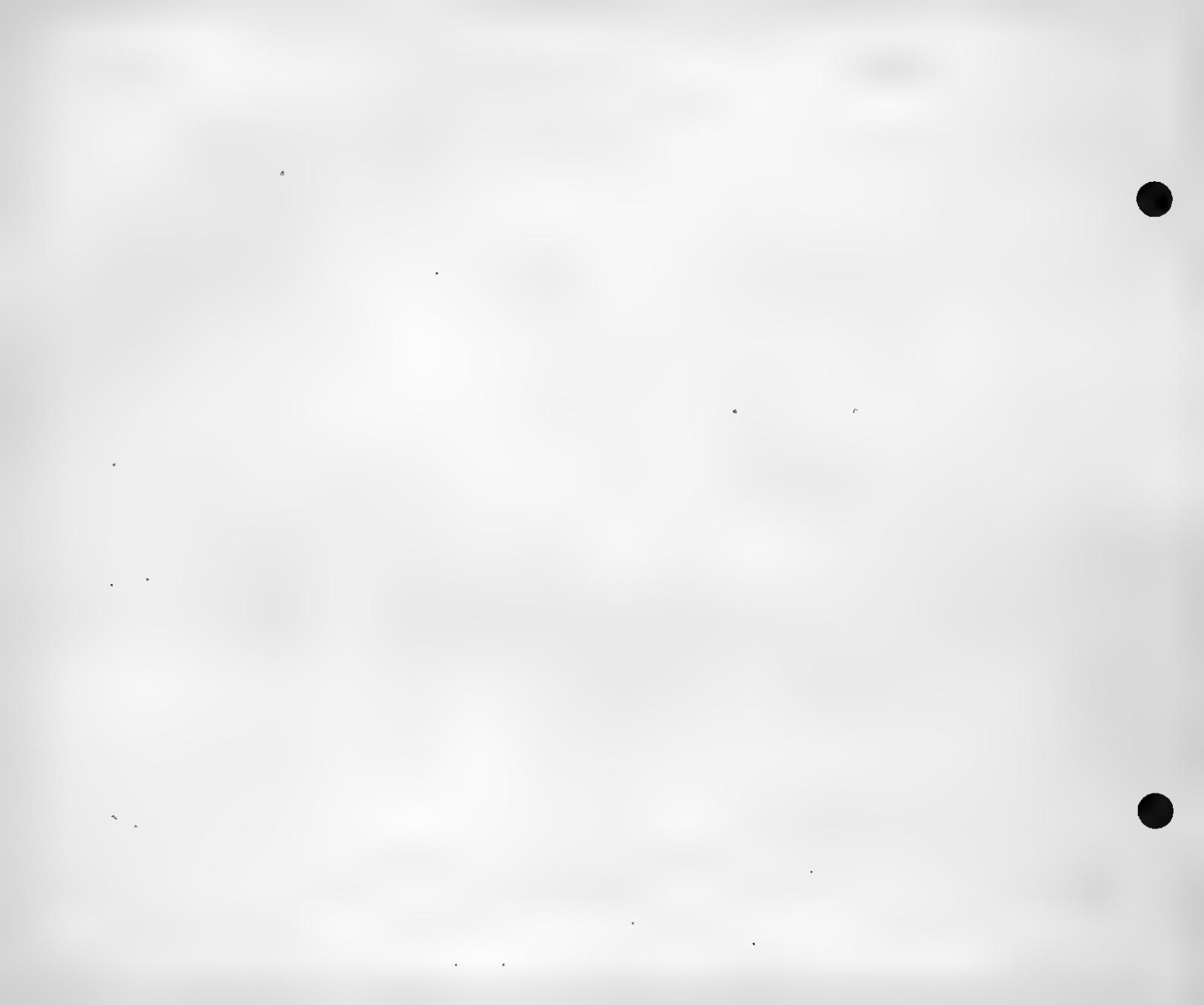


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

7208		17206					
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) c. LENGTH OF STAY IN 1b 18 days d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) RICHARD First WALTER Middle EVANS Last JR.		4. DATE OF DEATH Month 12 Day 08 Year 1967					
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/24/29		9. AGE (in years last birthday) 38 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bondsman		10b. KIND OF BUSINESS OR INDUSTRY salesman		11. BIRTHPLACE (County & State, or foreign country) California		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard W. Evans Sr.				14. MOTHER'S MAIDEN NAME Beatrice Whold			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes g ve war or dates of service) Yes unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital records		Address Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) 5x1.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) DUE TO (c)		EXSANGUINATION, Acute ESOPHAGEAL VARICES Gvrosis, Liver		INTERVAL BETWEEN ONSET AND DEATH Hours Months Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Congestive Heart Failure						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 20, 1967, to Dec. 8, 1967, that (I) (we) last saw the deceased alive on Dec. 8, 1967, and that death occurred at 12:45 P.M., from causes and on the date stated above							
22a. SIGNATURE Jack Shumacher		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12-9-67			
22c. PHYSICIAN'S NAME (Type) Dr. Jack Shumacher		22d. ADDRESS 105 Russell Ave., Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-12-67		23c. NAME OF CEMETERY OR CREMATORIAL Gaithersburg Cemetery		23d. LOCATION (City or Town) (County) (State) Gaithersburg 100-102 N. Main	
24. FUNERAL DIRECTOR Ernest C. Gartner		ADDRESS Gaithersburg, Md.		25a. RECD BY REGISTRAR Charles J. Judge		25b. REGISTRAR'S SIGNATURE Charles J. Judge	
VR A15 (1) 25M 1/62							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH												
17209						17207						
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE Ohio b. COUNTY Mahoning						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN TB 7 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Struthers						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20014 The Clinical Center, Bethesda, Md.						d. STREET ADDRESS 302 Maplewood Street						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3 NAME OF DECEASED (Type or print) Mary		First Mary Middle Ann		Last Fabek		4. DATE OF DEATH December 3 1967		Month December Day 3 Year 1967				
5 SEX Female		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 August 1957		9 AGE (In years last birthday) 10 yrs		10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (County & State, or foreign country) Ohio				
12. CITIZEN OF WHAT COUNTRY? USA												
13. FATHER'S NAME Thomas J. Fabek						14. MOTHER'S MAIDEN NAME Ann Susany						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT The Medical Records , The Clinical Center, Bethesda, Maryland 20014 <small>Address</small>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Low cardiac output INTERVAL BETWEEN ONSET AND DEATH 2 hours												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), (c), (d) last Post operative closure atrial septal defect, mitral valve replacement, subaortic infundibulotomy 2 days Congenital atrial septal defect, mitral valve replacement, subaortic stenosis												
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(If either notify medical examiner)</small>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 26 November 1967 to 3 December 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3 December 1967 , and that death occurred at 7:25 M, from causes and on the date stated above.												
22c. PHYSICIAN'S NAME (Type) Rudolf N. Staroscik, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-6-67			23c. NAME OF CEMETERY OR CREMATORIUM Calvary Cemetery			23d. LOCATION (City or Town) Youngstown, Ohio			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland			25a. REC'D BY REGISTRAR DEC 7 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17208

G. Montgomery CERTIFICATE AMENDED G. Montgomery, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

1 PLACE OF DEATH COUNTY <u>Montgomery</u>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>MARYLAND</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bensington</u>		c. LENGTH OF STAY IN Tb <u>4 yrs - since</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bensington Gardens Sanitarium</u>		e. STREET ADDRESS <u>Wheaton, Md.</u>		
3. NAME OF DECEASED (Type or print) <u>Alfonso,</u>		First	Middle	
4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1967</u>	Last	Month	Day	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-1893</u>	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>74 yrs</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wason Contractor</u>	11. BIRTHPLACE (County & State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>ANTHONY FAGNANI</u>		14. MOTHER'S MAIDEN NAME <u>ROSE UNKNOWN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>068-07-7234</u>	17. INFORMANT <u>Pauline Fagnani</u> Address <u>2617 Blue Ridge Dr., Wheaton, Md.</u>	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days.</u>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Viral</u>				
DUE TO (c)				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome 3 1/2 yrs; Diabetes mellitus</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>June 10</u> 19 <u>67</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.)	20f. (City or town) <u>Wheaton</u> (County) <u>Maryland</u> (State) <u>MD</u>
21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1967</u> to <u>June 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 10, 1967</u> , and that death occurred at <u>9:40 P.M.</u> from causes and on the date stated above.				22b. DATE SIGNED <u>June 10, 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>Bertram F. Schaefer MD</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. ADDRESS <u>1780 Mass. Ave. N.W. Washington, D.C. 20012</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>13 Dec. 1967</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>GATE OF HEAVEN Cemetery</u>	23d. LOCATED ON (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Rinaldi Funeral Home 9400 Georgia Ave. N.W.</u>		ADDRESS <u>DC 20012</u>	25a. REC'D BY REGISTRAR <u>DEC 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

DOCUMENTS ACCEPTED AS SUPPORTING EVIDENCE

1. To change _____
from _____
to _____

2. To change _____
from _____
to _____

Evidence returned _____ 19 _____ by _____

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17209

1 PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admisss on) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN 1b 1 hour		c CITY OR TOWN (If outside corporate limits, write RURAL and g ve nearest town) Silver Spring		d STREET ADDRESS 1714 Dublin Dr.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol, give street address) Holy Cross Hospital						e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Stanley Brooks Fairfax		First	Middle	Lost	4. DATE OF DEATH December	Month	Doy Year 19 19 67
5 SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/3/09	9 AGE (In years lost birthday) 58 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS DAYS Hours Min
10a USUA. OCC.PATION (G ve kind of work done during most of working life, even if retired) Mechanic		10b KIND OF BUSINESS OR INDUSTRY Soldiers Govt. Home		11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME				14 MOTHER'S MAIDEN NAME			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes q ue war or dates of service) Yes W.W. II		16 SOCIAL SECURITY NO		17 INFORMANT Stepson, John Haas		Address 1714 Dublin Dr. Sil. Spr., Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b) DUE TO (c)		Acute Coronary Insufficiency with fibrillation and Heart Block Coronary Artery Heart Disease.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b)		20d. INJURY OCCURRED Whle at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month Day, Year Hour o.m. p.m. 19		20f. (City or town) (County) (State)					
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Belden R. Reop. M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED Dec. 20, 1967	
EXAMINER'S NAME (Type) BELDEN R. REOP. M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street or town, county) Detention			
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-67		23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Wash. D.C.	
24. FUNERAL DIRECTOR Rinaldi Funeral Home, 7400 Georgia Ave.		ADDRESS Wash., DC		25a. REC'D BY REG STRAR DEC 26 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>	



FOR STATE
HEALTH DEPT.

O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event, with n 72 hours after death.

Items 18-21 Film 396 MARYLAND STATE DEPARTMENT OF HEALTH
1-15-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17214

1 PLACE OF DEATH a COUNTY MONTGOMERY				2 USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) b STATE MARYLAND			
b CITY OR TOWN (If outside corporate lim ts, write RURAL and give nearest town) TAKOMA PARK		c LENGTH OF STAY IN 1b DOA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d STREET ADDRESS 8110 TAHONA DR	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSP.				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) ROBERT HENRY FALES		First	Middle	Last	4 DATE OF DEATH 12 22 1967	Month	Day Year
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	W DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5-6-46	9 AGE (In years last birthday) 21 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Hours Min
10a USUA. OCC.PATION (G ve kind of work done during most of working life, even if retired) HELPER - SILVER SPRING IRON WKS.				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) MARYLAND	
13 FATHER'S NAME FRED L FALES				14. MOTHER'S MAIDEN NAME LOLA V. JAMESON		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No				16 SOCIAL SECURITY NO		17 INFORMANT WM L. FALES, Route 41, HAGERSTOWN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiorespiratory failure due to DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Carbon monoxide intoxication DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)							
20a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter natural injury in Part I or Part II of Item 1B) Deceased overcome by fumes from truck motor running in closed garage					
20c TIME OF INJURY Month Day, Year hour a.m. 8:00 AM 12-22 1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home farm factory, street or office bldg. etc) Garage	20f (City or town) Silver Spring Montg. Md.	(County)	(State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Keap M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) BELDEN R. KEAP M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town or County)							
22. DATE SIGNED DEC. 22, 1967							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Dec 26, 1967	23c NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		23d LOCATION (City or Town) Hagerstown (County) (State) MD		
24 FUNERAL DIRECTOR Takoma Funeral Home Inc. & Caskets		ADDRESS 254 Carroll St.	25a REC'D BY REGISTRAR DEC 27 1967		25b REGISTRAR'S SIGNATURE John J. Judge		



FOR STATE
HEALTH DEPT.

17213

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17211

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, G ve Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

I

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
f. STREET ADDRESS 8410 PARKCREST DR.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANN (NMN)		First ANN	Middle (NMN)
4. DATE OF DEATH FELDMAN 12 27 1967	Month 12	Day 27	Year 1967
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 7-10-1895
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 72 yrs
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME HARRIS SILVERSTEIN		14. MOTHER'S Maiden Name FANNIE MINNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 577-32-6117	
17. INFORMANT MR HERMAN FELDMAN (HUSBAND)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Dissecting aneurysm of ascending Aorta	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am pm 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) WATL MEMORIAL PARK
20f. (City or town) BELDEN, MD		(County) Montgomery	
		(State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED Dec. 28, 1967	
ACTUAL SIGNATURE Belden R. Keap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (if other than above county) 42179 NW	
23a. BURIAL, CREMATION, REINTERMENT (Specify) BURIAL		23b. DATE THEREOF 12-29-67	
23c. NAME OF CEMETERY OR CREMATORIAL FACILITY WATL MEMORIAL PARK		23d. LOCATION (City or Town) Falls Church	
24. FUNERAL DIRECTOR Index Funeral Home		ADDRESS 42179 NW	
25a. REC'D BY REGISTRAR DATE JAN 2 1968		25b. REGISTRAR'S SIGNATURE Lewis Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17212

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Colonial Villa Nursing Home		d. STREET ADDRESS 862 Azalea Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DAVID		First DAVID	Middle FE. D. L. A. N.
4. DATE OF DEATH Dec 20, 1967		Month December	Day 20 Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Aug. 20, 1897		9. AGE (In years last birthday) 70 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry Feldman		14. MOTHER'S MAIDEN NAME Rebecca Cohen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Sey. our Feldman		Address same as 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 421 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH A.S.H.D. acute myocardial infarction death Chronic coronary artery disease 17 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from July 1950 to Dec 20, 1967, that (I) (we) last saw the deceased alive on Dec 19, 1967, and that death occurred at 10:30 PM, from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE Herbert Wechsler		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/20/67
22c. PHYSICIAN'S NAME (Type) Herbert Wechsler		22d. ADDRESS 1800 Eye St NW Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-22-67	23c. NAME OF CEMETERY OR CREMATORIAL National Memorial Park
24. FUNERAL DIRECTOR Goldberg Funeral Home		ADDRESS 4217 9th St., N.W.	25a. REC'D BY REGISTRAR DEC 26 1967
			25b. REGISTRAR'S SIGNATURE O. Cleary Judge

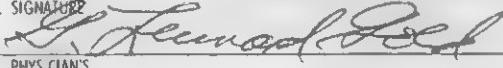


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			c. LENGTH OF STAY IN lb		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANATORIUM			e. STREET ADDRESS 7206 Flower Ave		
3. NAME OF DECEASED (Type or print) MARIA			First MARIA	Middle AMELIA	4. DATE OF DEATH 12-2-67
S. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-17-24	9. AGE (In years last birthday) yrs. 43
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CUBA	
13. FATHER'S NAME Diego Fernandez			14. MOTHER'S MAIDEN NAME Antonina Maria Paz		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT 11422 Rokeby Ave., Kensington Carlos Sera Brother-in-law	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 170X DUE TO Probable Pulmonary Embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO Adrenocarcinoma of Breast (c)					
INTERVAL BETWEEN ONSET AND DEATH 2 months 2 3/4 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from early 66 , 19, to 12/2 , 1967, that (I) (we) last saw the deceased alive on 11/29 , 1967, and that death occurred at 10:15 AM , from causes and on the date stated above					
22a. SIGNATURE 		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR 22d. ADDRESS 9801 Georgia Ave., Silver Spring, Md.	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 12/2/67	
22c. PHYSICIAN'S NAME (Type) G. Leonard Gold					
23a. BURIAL, CREMATION, BURIAL ALONE (Specify) Burial		23b. DATE THEREOF 12/5/67	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven	23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rock. Pike Rockville, Md.	25a. REC'D BY REGISTRAR DATE DEC 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL)				
c LENGTH OF STAY IN 1b 7mo 13 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		d STREET ADDRESS 500 S Ann st.				
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3 NAME OF DECEASED (Type or print) ROBERT LEE FILAR		First	Middle			
4 DATE OF DEATH 16 December 1967		Month	Day Year			
S. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH 9 Aug 1948		9. AGE (In years lost birthday) 19 yrs	F UNDER 1 YEAR Months Days Hours Min			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Military	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
13. FATHER'S NAME ALFRED A. FILAR SR.		14. MOTHER'S MAIDEN NAME PERZYNSKI				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 17 Nov. 66	17. INFORMANT LILIAN JEAN FILAR 500 S Ann St., Baltimore, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2041 DUE TO Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7Mo				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myelogenous Leukemia DUE TO (c)						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1b)				
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) Baltimore	(County) Md.	(State)
21 I certify that (I) (this hospital) attended the deceased from 3 May 1967 to 16 Dec 1967 , that (I) (we) last saw the deceased alive on 16 Dec 1967 , and that death occurred at 240 P.M. from causes and on the date stated above				22b DATE SIGNED		
22a. SIGNATURE <i>Charles S. Reeves</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Charles S. Reeves Lt MC USN		22d. ADDRESS NAVAL HOSPITAL BETHESDA, MARYLAND				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12/30/67	23c NAME OF CEMETERY OR CREMATORIAL ADDRESS Holy Rosary Cemetery	23d. LOCATION (City or Town) Baltimore	(County) Baltimore	(State) Md.
24. FUNERAL DIRECTOR Kaczrowski Funeral Home Baltimore, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 goes to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a. STATE	
Montgomery Maryland		Md Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c LENGTH OF STAY IN b Bethesda 6 days	c CITY OR TOWN (If outside corporate limits, write RURAL and g ve nearest town) Rockville	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda		d STREET ADDRESS 263 Congress Ave	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print)	First Ruth	Middle F.	Last Fischer
4 DATE OF DEATH Month Dec	Day 19	Year 1967	
5 SEX f	6 COLOR OR RACE w	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/19/1889
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Kentucky		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles		14. MOTHER'S MAIDEN NAME Mary M. Vetter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Guy Smith		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) lost.		Myocardial Infarction ASHD INTERVAL BETWEEN ONSET AND DEATH 8 days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Thrombosis		19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, off blog, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1964</u> to <u>12/19/67</u> , that (I) (we) last saw the deceased alive on <u>12/19/64</u> , and that death occurred at <u>1180</u> M, from causes and on the date stated above		22b. DATE SIGNED 12/19/67	
22c. PHYSICIAN'S NAME (Type) ROBERT C. MACON		22d. ADDRESS 809 Viers Hill Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-22-67	
23c. NAME OF CEMETERY OR CREMATORIAL Ft. Hill Mem. Park		23d. LOCAT ON (City or Town) (County) (State) Lynchburg, Virginia	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE DEC 26 1967	
		25b. REG STRAR'S SIGNATURE Signature	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17216

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL)		c. LENGTH OF STAY IN b. 19 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		e. STREET ADDRESS 1307 HANOVER ST.	
3. NAME OF DECEASED (Type or print) ERNEST		First FONDREN	Middle Last DECEMBER 16 1967
S. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 9 March 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Justice of Peace		10b. KIND OF BUSINESS OR INDUSTRY Military	9. AGE (in years last birthday) 74 yrs
13. FATHER'S NAME Henry J. Fondren		11. BIRTHPLACE (County & State, or foreign country) Marion, Alabama	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 1912-1945		16. SOCIAL SECURITY NO Not known	17. INFORMANT Mrs. Nannie L. Fondren
Information not available			
<i>Address</i> 1307 Hanover St., Fredericksburg, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Lung		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 163 X		DUE TO (b) _____	
		DUE TO (c) _____	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PNEUMONITIS, DIFFUSE, BIILATERAL			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 27 Nov 1967 , to 16 Dec 1967 , that (I) (we) last saw the deceased alive on 16 Dec 1967 , and that death occurred on 1955A M. from causes and on the date stated above.			
22a. SIGNATURE <i>E. Perlin</i>		22b. DATE SIGNED 16 Dec 1967	
22c. PHYSICIAN'S NAME (Type) E. Perlin, Lcdr MC USN		22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-18-67	
23c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Fredericksburg Va.	
24. FUNERAL DIRECTOR WHEELER AND THOMPSON		ADDRESS FREDERICKSBURG, VA.	
		25a. REC'D BY REGISTRAR DEC 21 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE	
Montgomery MARYLAND		Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Silver Spring 1 month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Holy Cross Hospital		d. STREET ADDRESS 11106 Woodson Ave.	
3 NAME OF DECEASED (Type or print)		4 DATE OF DEATH Month Day Year	
First Yvonne		Middle M. Last December 7 1967	
5 SEX F		6. COLOR OR RACE W	
7 MARRIED WIDOWED		8. DATE OF BIRTH Wec. 20, 1893	
<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED		9. AGE (in years last birthday) 73 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife never employed		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England	
13. FATHER'S NAME Edward Jeffreys		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO No	
17. INFORMANT Mrs. Daphne Hill		Address 11106 Woodson Avenue Kensington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Uremia due to Pyelonephritis</i> INTERVAL BETWEEN DUE TO <i>death</i> ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost <i>6 months</i>			
(b) <i>Congestive heart failure</i> DUE TO <i>death</i> 6 months			
(c) <i>Healed myocardial infarct</i> DUE TO <i>death</i> 6 months			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FERNAL DISEASE CONDITION GIVEN IN PART I (c) <i>Arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED Wh. e. Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1, 1967</i> to <i>Dec. 7, 1967</i> that (I) (we) last saw the deceased alive on <i>Dec. 7, 1967</i> , and that death occurred on <i>Dec. 7, 1967</i> M, from causes and on the date stated above		22b. DATE SIGNED <i>12/7/67</i>	
22c. SIGNATURE <i>Glen J. Curry</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) John J. Curry		22d. ADDRESS <i>10620 Georgia Avenue</i>	
23a. BURIAL, CREMATON, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 9, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR <i>Glen Carter #434 Georgia Avenue Warren E. Pumphrey, Inc. Silver Spring, Md.</i>		25a. RECD. BY REGISTRAR <i>REC'D. BY REGISTRAR</i>	
		25b. REGISTRAR'S SIGNATURE <i>Judge</i>	
		DATE <i>DEC 11 1967</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

John G. Ball

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Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

John G. Ball

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) b. STATE	
<i>Montgomery Maryland</i>		<i>Maryland Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>41 Westwood Lane</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <i>Anthony</i>	Middle <i>Tartier</i>	Last <i>Ste. 10 1967</i>
4 DATE OF DEATH	Month	Day	Year
S SEX	5 COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Sept 30, 1909</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plant operator</i>	10b KIND OF BUSINESS OR INDUSTRY <i>New Hampshire C.S.A.</i>	9 AGE (In years last birthday) <i>58 yrs</i>	11 IF UNDER 24 HRS Months Dots Hours Min.
13 FATHER'S NAME <i>Joseph Tartier</i>	14 MOTHER'S MAIDEN NAME <i>Lorraine Habris</i>	12 CITIZEN OF WHAT COUNTRY <i>New Hampshire C.S.A.</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No or unknown) <input type="checkbox"/> Yes give war or dates of service <i>1945-1946</i>	16 SOCIAL SECURITY NO <i>003-17-6911</i>	17 INFORMANT <i>Mrs. Millie Cox</i>	18 ADDRESS <i>1201 Rockville Pike</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Myocardial Infarction, Recent & Remote		<i>Acute 21 min.</i>	
DUE TO (b) Coronary arteriosclerosis with occlusion			
DUE TO (c) Po			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Esophago-gastrostomy, post 5 days, for carcinoma esophagus</i>			
20a EXTERNA CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <i>Blow to abdomen</i>	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home farm factory, street, office building, etc.)
20f (City or town) (County) (State)		20g (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <i>7936 Old Georgetown Road, Bethesda, Maryland</i>	
22. DATE SIGNED <i>Dec 12, 1967</i>			
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF <i>12/14/67</i>	23c NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery
23d LOCATION (City or Town) (County) (State) <i>Silver Spring, Md.</i>		23e LOCATION (City or Town) (County) (State)	
24 FUNERAL DIRECTOR <i>Tyson Wheeler</i>		25a ADDRESS <i>1331 Rockville Pike Rockville, Maryland</i>	25b REC'D BY REGISTRAR DATE <i>DEC 15 1967</i>
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17219

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> <i>Maryland</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) d. STATE <i>Washington, D.C.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Springfield</i>		c. LENGTH OF STAY IN lb <i>3 1/2 yrs</i>					
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colonial Villa Nursing Home</i>		e. STREET ADDRESS <i>3636 S. Street, N.W.</i>					
3 NAME OF DECEASED (Type or print) CAROLINE		First H	Middle FOSTER				
S. SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House - wife</i>		10f. KIND OF BUSINESS OR INDUSTRY <i>at home</i>					
11 BIRTHPLACE (County & State, or foreign country) <i>New York</i>		9 AGE (In years last birthday) <i>85 yrs</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13 FATHER'S NAME Hiram G. Hotchkiss		14 MOTHER'S MAIDEN NAME Louise W. Knowles					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>3636 S St. NW Wash. DC</i>					
17. INFORMANT Mary L. Charles		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Generalized Arteriosclerosis</i> DUE TO DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs.</i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Arthritis, generalized, Fracture l. hip.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>January</i> , 19 <i>65</i> , to <i>12/9</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>12/9</i> 19 <i>67</i> , and that death occurred at <i>5:15 P.M.</i> , from causes and on the date stated above							
22a. SIGNATURE <i>Seymour Greenbaum</i>		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>12/9/67.</i>				
22c. PHYSICIAN'S NAME (Type) <i>Seymour Greenbaum, M.D.</i>		22d. ADDRESS <i>1800 Eye St. N.W. Washington, D.C.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>		23b. DATE THEREOF <i>12/11/1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) <i>Suitland, Md.</i>	(County) <i>—</i>	(State) <i>—</i>
24. FUNERAL DIRECTOR <i>Joseph Lawlor's Sons</i>		ADDRESS <i>5130 Wisconsin Ave. NW Washington, DC</i>		25a. REC'D BY REGISTRAR <i>Charter</i>	25b. REGISTRAR'S SIGNATURE <i>Charter</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Then please sign and date the certificate, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
17222 Item #23c Film #396					CERTIFICATE OF DEATH				
17220									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE South Carolina b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN 1b 62 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lyman				
d. STREET ADDRESS 8 Crest Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary					First Ruth	Middle Fowler	Last Fowler	4. DATE OF DEATH December 17	Month Year 1967
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8 January 1915	9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stitcher				10b. KIND OF BUSINESS OR INDUSTRY Printing			11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ray Powell					14. MOTHER'S MAIDEN NAME Mary A. Case				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No					16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland		
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 201X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) Brain abscess DUE TO (c) Hodgkin's Disease post radiotherapy DUE TO					INTERVAL BETWEEN ONSET AND DEATH 2 weeks weeks 3 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Oct. 16, 1967, to Dec. 17, 1967, that (X) (we) last saw the deceased alive on Dec. 17, 1967, and that death occurred at 11:00M, from causes and on the date stated above.									
22a. SIGNATURE F. C. Grumet MD					A.M. MED STAFF M.D. ATTENDING PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 1967 17 December				
22c. PHYSICIAN'S NAME (Type) Frank C. Grumet, MD					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE THEREOF Dec 18, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Wood Mem. Park, Route 6		23d. LOCATION (City or Town) (County) (State) Greer, S. C. Spartanburg Co			
24. FUNERAL DIRECTOR Joseph Gawler's Sons 5130 Wisc, Ave. N.W. Wash.					ADDRESS D.C. 25a. REC'D BY REGISTRAR DATE DEC 26 1967 25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17221

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE District of Columbia												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb Washington												
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chevy Chase Nursing & Convalescent Center		e. STREET ADDRESS 2737 Devonshire Pl., N. W.												
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) RITA G. FRANK		First RITA	Middle G.											
4. DATE OF DEATH December 31 1967		Last FRANK	Month Day Year											
5. SEX Female		6. COLOR OR RACE Caucasian	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1887	9. AGE (In years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0				
10b. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (County & State, or foreign country) San Francisco, Calif.			12. CIT ZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Berthold Grunebaum		14. MOTHER'S MAIDEN NAME Nanette Blum												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO unknown		17. INFORMANT Mrs. B.C. Sanders		Address 2705 Navarre Drive Chevy Chase, Md. 20015								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumo - Pneumonia		DUE TO 491X		DUE TO { Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Subarachnoid hemorrhage -														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) July 12/31		(County) 1967		(State) DC				
21. I certify that (I) (this hospital) attended the deceased from July 1967 to 12/31 1967 , that (I) (we) last saw the deceased alive on 12/3 1967 , and that death occurred at 345P.M. from causes and on the date stated above														
22a. SIGNATURE Samuel DeSoff		M.D. ATTENDING PHYS IV MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/31/67										
22c. PHYSICIAN'S NAME (Type) SAMUEL DESSOFF		22d. ADDRESS 1302-18ST-N.W. MSH DC												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/4/68		23c. NAME OF CEMETERY OR CREMATORIAL Washington Hebrew Congregation		23d. LOCATION (City or Town) Washington, D. C.		(County) DC		(State) DC				
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Wash., D. C.		ADDRESS		25a. REC'D BY REGISTRAR JAN 5 1968		25b. REGISTRAR'S SIGNATURE Charles J. ...								



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 9 Film G396 7/5/68 k

CERTIFICATE OF DEATH

17222

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician.

To FEDERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
<i>Maryland</i> <i>Maryland</i>		<i>Maryland</i> <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 11 days	
b. <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Tuberculosis</i>	
d. <i>Tuberculosis</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>El. 11/12/67</i>	Middle <i>G</i>	Last <i>Fitzpatrick</i>
4. DATE OF DEATH	Month <i>Dec</i>	Day <i>25</i>	Year <i>1967</i>
5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>Male</i>	<i>White</i>	<i>Widowed</i>	<i>Never married</i>
8. DATE OF BIRTH <i>3/11/31</i>	9. AGE IN YEARS <i>36</i>	10. IN years <i>36</i>	11. IN years <i>36</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Surgeon</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Surgeon</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Florida</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>George Thompson</i>	14. MOTHER'S MAIDEN NAME <i>Frances Kirkpatrick</i>	Address <i>5100 Wisconsin Ave Bethesda MD 20816</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO <i>261-36-7239</i>	17. INFORMANT <i>Robert Franklin</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Subarachnoid & Intrapontine hemorrhage, spontaneous</i>
		INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>ruptured congenital aneurysm, right cerebellar artery</i>		DUE TO (b) DUE TO (c)	
		11 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>8218 Wisconsin Ave Bethesda MD</i>
		20f. (City or town) <i>Bethesda</i>	(County) <i>Maryland</i>
		(State) <i>MD</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>12-17</i> , 19 <i>67</i> , to <i>12-25</i> , 19 <i>67</i> , that (I) (was) last seen the deceased alive on <i>12-25-67</i> , and that death occurred at <i>8218 Wisconsin Ave Bethesda MD</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Francis C. Mayle Jr. MD</i>		22b. ATTENDING MED. PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>Francis C. Mayle Jr. MD</i>		22d. ADDRESS <i>8218 Wisconsin Ave Bethesda MD</i>	22e. DATE SIGNED <i>12/20/67</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF <i>12-28-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>
23d. LOCATION (City or Town) <i>Rockville</i>		(County) <i>Maryland</i>	
		(State) <i>MD</i>	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	25b. REC'D BY REGISTRAR DATE DEC 29 1967
		25b. REGISTRAR'S SIGNATURE <i>no</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17223

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1004 DeBeck Drive		d. STREET ADDRESS 1004 DeBeck Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Rose	First Rose	Middle Anne	Last Frazier
4 DATE OF DEATH December 16, 1967	Month December	Day 16	Year 1967
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1883
9. AGE (In years last birthday) 84 yrs.	10. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Benjamin Thomas	14. MOTHER'S MAIDEN NAME Mary Katherine Cooley		
15. WAS DECASSED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO	17. INFORMANT Mary Phoebus - Niece - 541 Brent Road	Address Rockville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac decompensation & myocardial failure</i> DUE TO <i>Arteriosclerotic cardiovascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic cardiovascular disease</i> (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) Rockville (County) Maryland (State) MD		21. I certify that (I) (this hospital) attended the deceased from Dec 1966, 19 to Dec 16, 1967 , that (I) (we) last saw the deceased alive on Dec 15 1967 , and that death occurred 12/16/67 A.M. from causes and on the date stated above.	
22a. SIGNATURE <i>W.A. Smith</i>		22b. DATE SIGNED 12/17/67	
22c. PHYSICIAN'S NAME (Type) W.A. Smith, MD		22d. ADDRESS 110 S. Washington St. Rockville, Md.	
23a. BURIAL, CREMATION, BURIAL (Specify) Burial		23b. DATE THEREOF 12/19/67	23c. NAME OF CEMETERY OR CREMATORIAL Clarksburg Cemetery
23d. LOCATION (City or Town) Clarksburg, Maryland		(County) Maryland (State) MD	
24. FUNERAL DIRECTOR Tyson Wheeler		25a. ADDRESS 1331 Rockville Pike	25b. REC'D BY REGISTRAR DEC 21 1967
		25c. ADDRESS Rockville, Maryland	25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital						d. STREET ADDRESS 402 Lexington Drive							
3. NAME OF DECEASED (Type or print)			First Marian	Middle Esther	Last Frech	4. DATE OF DEATH Month December Day 21 Year 1967			5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-9-90			9. AGE (In years last birthday) yrs. 79				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF.				10b. KIND OF BUSINESS OR INDUSTRY Civil Home				11. BIRTHPLACE (County & State, or foreign country) Washington D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Albertus Wilson						14. MOTHER'S MAIDEN NAME Cora							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) No						16. SOCIAL SECURITY NO. 72-18-54-							
17. INFORMANT Hospital Records						Address 7600 Carroll Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute severe cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Generalized arterio sclerosis DUE TO DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH 4 days Several years													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> or work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) Bethesda (County) Montgomery (State) Md.													
21. I certify that (I) (this hospital) attended the deceased from 1966 , 19, to December 21, 1967, that (I) (we) last saw the deceased alive on December 20, 1967 , and that death occurred at 232A M, from causes and on the date stated above.													
22a. SIGNATURE Bennet A. Porter Jr.						M.O. A. Porter ATTENDING PHYS <input checked="" type="checkbox"/> ME.O. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED December 21, 1967				
22c. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D.						22d. ADDRESS 9301 Colesville Rd., Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Dec 23, 1967			23c. NAME OF CEMETERY OR CREMATORIAL Pock Creek Cemetery			23d. LOCATION (City or Town) Washington (County) D.C. (State)				
24a. FUNERAL DIRECTOR Glen Porter			24b. ADDRESS 8424 Columbia Rd. N.W.			25a. REG'D BY REGISTRAR J. Charles Judge			25b. REGISTRAR'S SIGNATURE				
25c. DATE DEC 28 1967													



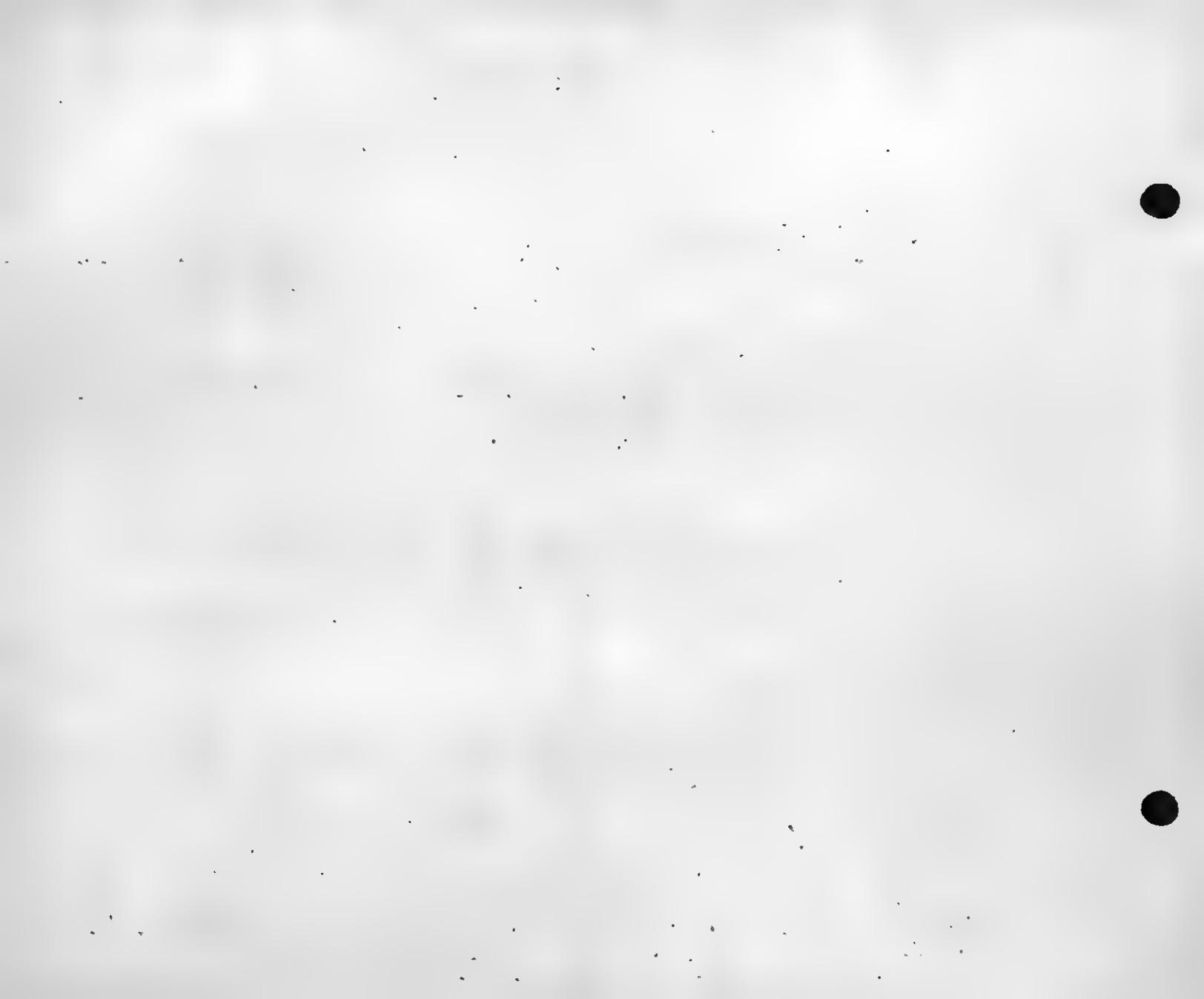
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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Received medical treatment

CERTIFICATE OF DEATH				2d. HOUR				
1. DECEASED NAME (Type or print)		First KATE	Middle CLYDE	LAST FREEMAN	2d. DATE OF DEATH Month 12	Doy 26	Year 67	8:00 P.M.
3. SEX F		4. RACE Cauc	5. DATE OF BIRTH 12-10-1893	6. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR MONTHS 02	IF UNDER 24 HRS. HOURS 00	IF UNDER 12 HRS. MIN. 00
7a. BIRTHPLACE (State or foreign country) ALAMANCE C. O. NC. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH MONTGOMERY ALABAMA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNIVERSITY NURSING		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) GENERAL OFFICE WORKER		12b. KIND OF BUSINESS OR INDUSTRY not		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 8607 PINE / BRANCH			
14. FATHER'S NAME First HAY		Middle wood	Last CLENDENIN	15. MOTHER'S MAIDEN NAME First ALLIE ?	Middle (11-1941)	Last Richard Conway	16. ADDRESS 4707 Address, turned to eat 111-111-1111	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiovascular collapse 4. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause Arteriosclerotic heart disease years 10 minutes								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Iron deficiency, anemia; childhood								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from March 1961 to 12-26, 1967 , that (I) (we) last saw the deceased alive on 12-7-1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE John Geiger, M.D.		DEGREE JASON GEIGER, M.D.	ATTENDING PHYS MED. DIRECTOR	STAFF PHYS STAFF PHYS	22c. DATE SIGNED 12-26-67			
22d. PHYSICIAN'S NAME (Type) JOHN GEIGER, M.D.		22e. ADDRESS 800 PERSHING DRIVE SILVER SPRING MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE Dec. 29, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION (City or Town) Prince George's County		(County) Prince George's County	(State) MD
24. FUNERAL DIRECTOR John Geiger, M.D.		ADDRESS 800 Pershing Drive Silver Spring, MD.	25a. REC'D BY REGISTRAR JHN		25b. REGISTRAR'S SIGNATURE JHN			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN b <i>10 1/2 hrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
3. NAME OF DECEASED (Type or print) IDA		4. DATE OF DEATH Dec 28 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11/2/1909		9. AGE (in years last birthday) 58 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? A.S.A.	
13. FATHER'S NAME Zachary		14. MOTHER'S MAIDEN NAME Gertrude Epstein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracranial hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X (b) Cerebral arteriosclerosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or Town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 27 Dec 1967 to 28 Dec 1967 , that (I) (we) last saw the deceased alive on 27 Dec 1967 , and that death occurred at 5:55 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Zachary (Z) Bernton</i>		22b. DATE SIGNED 12/28/67	
22c. PHYSICIAN'S NAME (Type) Horace W. Bernton		22d. ADDRESS 4743 Bradley Blvd. Ch. Ch. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-67	23c. NAME OF CEMETERY OR CREMATORIAL King David MELL-Garden
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Berney & Sons 3501-12th St. N.W.		25a. ADDRESS JAN 2 1968	25d. REGISTRAR'S SIGNATURE JAN 2 1968
25b. REC'D BY REGISTRAR JAN 2 1968			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>	
d. STREET ADDRESS <i>41 Meadow Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (First, Middle, Last name and middle initial) <i>Andrew Edmund Friedrich</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>28</i> Year <i>1967</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <i>8-5-15</i>		10. AGE (In years last birthday) <i>52 yrs</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Penn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Andrew Friedrich</i>		14. MOTHER'S MAIDEN NAME <i>Kaydra</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>4077-XXXX-X444</i>	
17. INFORMANT <i>Jocetta Friedrich w/w - add some</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial infarct, recent</i> DUE TO (c) <i>Coronary Atherosclerosis</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 1967, to <i>Dec 23</i> , 1967, that (I) (we) last saw the deceased alive on <i>Dec 23</i> , 1967, and that death occurred at <i>600A.M.</i> from causes and on the date stated above.		22b. DATE SIGNED <i>12/23/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>GEORGE H. MITCHELL, M.D.</i>		22d. ADDRESS <i>11125 Rockville Pike, Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-27-67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel National Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR <i>Dell Witt Clarendon Laurel Md.</i>		25a. REC'D BY REGISTRAR <i>JAN 3 1968</i>	
		25b. REGISTRAR'S SIGNATURE <i>George H. Mitchell</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 16 <i>3 months</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Colonial Villa 12325 New Hampshire Ave</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring (Hillendale)</i>		f. STREET ADDRESS <i>1616 Oaklawn Court</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Carrie FRENCH French</i>		First	Middle	Last	4. DATE OF DEATH Month <i>12 - 28 - 67</i>	Day	Year		
S. SEX <i>F</i>	6. COLOR OR RACE <i>Wh-</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>1-21-1896</i>	9. AGE (In years last birthday) <i>81 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Clerk</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Dept. Agriculture</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Michigan</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Lucius French</i>		14. MOTHER'S MAIDEN NAME <i>Anna (unknown)</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>579-44-6843</i>		17. INFORMANT <i>Hillendale Maryland Sarah F. Mears-1616 Oaklawn Court</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>						INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerotic heart disease</i>		DUE TO (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>10820 Georgia Avenue, Wheaton, Maryland</i>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 2, 1967</i> to <i>12/28, 1967</i> that (I) (we) last saw the deceased alive on <i>Dec 19, 1967</i> , and that death occurred at <i>10820 Ga. Avenue, Wheaton, Maryland</i> from causes and on the date stated above									
22a. SIGNATURE <i>B. G. Bender</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>12/28/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>B.G. Bender</i>		22d. ADDRESS <i>10820 Georgia Avenue, Wheaton, Maryland</i>							
23a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>Jan. 2, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL FACILITY <i>C. Glen Carter 8434 Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Suitland, Maryland</i>			
23e. ONE APPOINTED <i>Warner E. Pumphrey, Inc. Silver Spring, Md</i>		23f. ADDRESS <i>Ga. Avenue</i>		23g. REC'D BY REGISTRAR <i>JAN 8 1968</i>		23h. REG STRR'S SIGNATURE <i>Charles J. ...</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11313 Old Club Road		d. STREET ADDRESS 11313 Old Club Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Cecil	Middle Forest	Last Frost
4. DATE OF DEATH December 21, 1967	Month	Doy	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8/16/05	9. AGE (In years and birthday) 62 yrs.	10. IF UNDER 24 HRS. Months	11. IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Texas	
13. FATHER'S NAME Cecil R. Frost	14. MOTHER'S MAIDEN NAME	12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 532-09-7948	17. INFORMANT Cecil R. Frost - son same item # 2	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause _____ last. (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 13 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I (this hospital) attended the deceased from Aug 23, 1967 , to 12-21, 1967 , that I (we) last saw the deceased alive on 12-8 1967 , and that death occurred at 6:30 p.m. from causes and on the date stated above			
22a. SIGNATURE Alfred S. Norton		22b. DATE SIGNED 12/22/67	
22c. PHYSICIAN'S NAME (Type) Alfred S. Norton, M.D.		22d. ADDRESS 7710 Dwight Drive, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/67	23c. NAME OF CEMETERY OR CREMATORIAL Woodland Cemetery
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		23d. LOCATION (City or Town) (County) (State) Rockville Pike	25b. REG'D BY REGISTRAR Judge
		DATE DEC 28 1967	REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>5807 Larkton Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>WILLIAM</i>	Middle <i>BARRETT</i>	Last <i>Fuchs</i>
4. DATE OF DEATH Month <i>Dec</i>	Day <i>25</i>	Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>12/4/08</i>
9. AGE (In years last birthday) <i>59</i>	10. KIND OF BUSINESS OR INDUSTRY <i>District School System</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Wash. D.C. U.S.A.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William Robert Fuchs</i>	14. MOTHER'S MAIDEN NAME <i>Georgia Barrett</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO <i>16. SOCIAL SECURITY NO</i>		17. INFORMANT Wife <i>Anne Pyle Fuchs</i>	Address <i>Same as Item 2.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <i>Massive right intracerebral hemorrhage, spontaneous</i>			
DUE TO <i>220X</i>			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause <i>rupture of right middle cerebral artery</i>			
DUE TO <i>Cerebral arteriosclerosis & Hypertensive heart disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
DUE TO <i>last</i>			
years <i>4 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>Nov. 1962</i> to <i>Dec 25, 1967</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>Dec 24 1967</i> , and that death occurred at <i>195 M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Alfred S. Norton</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>ALFRED S. NORTON</i>		22d. ADDRESS <i>7710 Dwight Drive Bethesda, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-28-67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cem.</i>
23d. LOCATION (City or Town) (County) (State) <i>Prince George County, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 29 1967</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician

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1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY C	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Roy Garland		Last December	Month December Day 5 Year 1967
4. SEX M	5. COLOR OR RACE W	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. DATE OF BIRTH July 15, 1885
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. AGE (in years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent		11. BIRTHPLACE (County & State, or foreign country) Altoona, Pennsylvania	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO YES	
17. INFORMANT Mrs. Jeannette Garland		Address 87 Colonial Ave., Pitman, New Jersey	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Kidney edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Myocardial infarct		INTERVAL BETWEEN ONSET AND DEATH Hours 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) While at work	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 67 , to 12/5 , 19 67 , that (I) (we) last saw the deceased alive on 12/4 , 19 67 , and that death occurred at 11:50 A.M. from causes and on the date stated above.		20f. (City or town) Washington Twp. (County) New Jersey (State)	
22a. SIGNATURE Richard Delaney		22b. DATE SIGNED 12/5/1967	
22c. PHYSICIAN'S NAME (Type) Richard Delaney		22d. ADDRESS 4323 Howard St., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 7, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Memorial Park		23d. LOCATION (City or Town) Washington Twp., New Jersey (County) New Jersey (State)	
24. FUNERAL DIRECTOR C. K. Carter		ADDRESS 8434 Georgia Avenue, Silver Spring, Maryland	
		25a. REC'D BY REGISTRAR Charles Judge	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



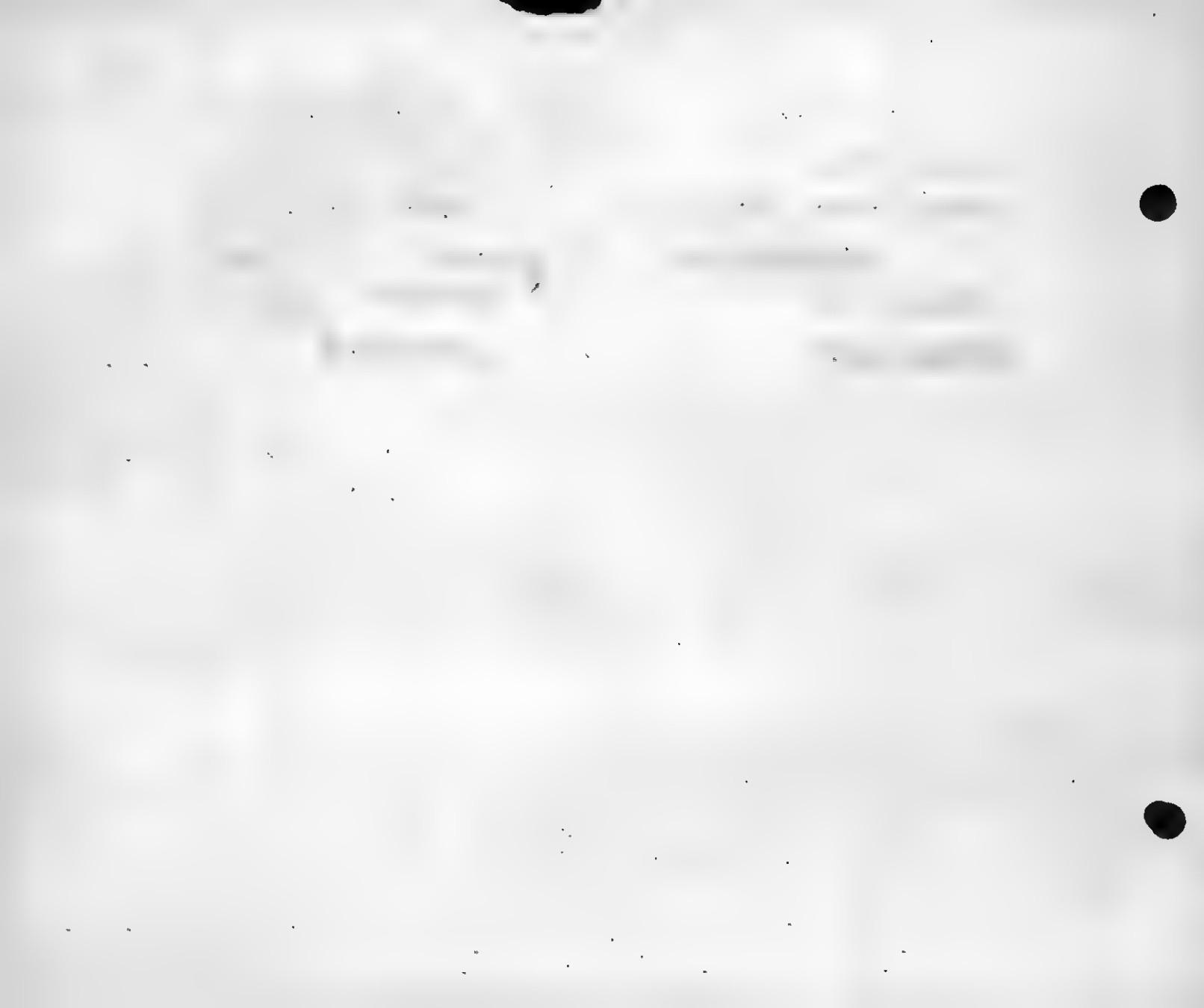
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 21 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		e. STREET ADDRESS 9933 MOSS AVE.	
3. NAME OF DECEASED (Type or print) Gwendoline		First G	Middle WEACH
4. DATE OF DEATH DEC. 28 1967		Last G	Month DEC.
5. SEX FEMALE		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GOLF.		10b. KIND OF BUSINESS OR INDUSTRY Labor Consultant	
11. BIRTHPLACE (County & State, or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Geach		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Norine Diamond		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Carcinomatous invasion of Liver	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH approx 6 weeks	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Primary Carcinoma of Stomach	
		DUE TO (c) Illness	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? NO	
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) White at work	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED Not White at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1106 SOARST ST SILVER SPRING MD.
20f. (City or town) Dec 28 1967		(County) MD.	
(State) 1967			
21. I certify that (I) (this hospital) attended the deceased from Dec 7, 1967 , to Dec 28, 1967 , that (II) (we) last saw the deceased alive on Dec 27, 1967 , and that death occurred at 6106 Soarst St Silver Spring MD. from the causes and on the date stated above.			
22a. SIGNATURE Gene U. Cohen M.D.		22b. DATE SIGNED Dec 28 1967	
22c. PHYSICIAN'S NAME (Type) Gene U. Cohen M.D.		22d. ADDRESS 1106 Soarst St Silver Spring MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 28, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Particular Cemetery
24. FUNERAL DIRECTOR John J. Thomas, Jr.		ADDRESS 1106 Soarst St Silver Spring MD.	25a. REC'D BY REGISTRAR J. J. 2 1968
			25b. REGISTRAR'S SIGNATURE Charles J. Geach



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

PAGE 4
Form PN3
Page 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PN3. Page 3 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PN3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) d. STATE	
Montgomery Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb 15 min.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laytonsville	
b. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Agustus Thomas Gibson		First	Middle
4. DATE OF DEATH Dec. 5 1967		Month	Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED W DIVORCED	8. NEVER MARRIED DOWED
9. DATE OF BIRTH April 6, 1897		9. AGE (In years at birthday) 40 yrs	
10. OCCUPATION (Give kind of work done during most of working life, even if retired) FUCK Driver		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Augustus Thomas Gibson, Sr.		14. MOTHER'S MAIDEN NAME Beatrice Barber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 578-36-2944	
17. INFORMANT Charlotte Gibson		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Insufficiency Acute - Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Due to (c)	
INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PR/MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20e. PLACE OF INJURY (Name, farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John G. Ball	
23a. BURIAL CREMATION, REMOVALS (if any) Burial		23b. DATE THEREOF 12-8-67	
23c. NAME OF CEMETERY OR CREMATORIAL Laytonsville		23d. LOCATION (City or Town) Laytonsville, Mont. Md.	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville, Md.	
25a. RECEIVED BY REGISTRAR DATE DEC 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Items 13 & 14 Film G396 1/2/68 CERTIFICATE OF DEATH

17234

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be retained by the hospital or attending physician.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5304 Flanders Ave.		d. STREET ADDRESS 5304 Flanders Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ANGELO	Middle G.	Last GOFFREDO	4. DATE OF DEATH Dec. 21, 1967	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1887	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Merchant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Bari, Italy	
13. FATHER'S NAME Vakhtovn		14. MOTHER'S MAIDEN NAME Felice Goffredo		12. CITIZEN OF WHAT COUNTRY? U. S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 233-54-6723	17. INFORMANT Daughter	Address Angelina Goffredo		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Acute congestive heart failure Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic heart disease (c)					
INTERVAL BETWEEN ONSET AND DEATH 4 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① Phlebitis vulgaris ② Cystitis of bladder					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19 to Dec. 21 , 1967, that (I) (we) last saw the deceased alive on Dec. 21 , 1967, and that death occurred at 1 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Robert N. Coale					
22b. DATE SIGNED Dec 21 1967					
22c. PHYSICIAN'S NAME (Type) ROBERT N. COALE	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-23-67	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cem.	23d. LOCATION (City, town or county) (State) Silver Spring, Md.		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.	ADDRESS	25a. REC'D BY REGISTRAR DEC 29 1967	25b. REGISTRAR'S SIGNATURE		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						17235		
1. PLACE OF DEATH a. COUNTY Montgomery			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN lb 13 days		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William	Middle Samuel	Last Goodman	4. DATE OF DEATH December 30 1967	Month December	Day 30	Year 1967
5. SEX Male	6 COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-5-03	9. AGE (In years lost b. birthday) 64 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0
10a. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Forman			10b. KIND OF BUSINESS OR INDUSTRY D. C. Transit			11. BIRTHPLACE (County & State, or foreign country) Virginia		
13. FATHER'S NAME Samuel W. Goodman			14. MOTHER'S MAIDEN NAME Mary Moon			12. CITIZEN OF WHAT COUNTRY? America U.S.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no			16. SOCIAL SECURITY NO 578 10 7813			17. INFORMANT Patient's chart		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) -Congestive heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) Coronary Heart Disease DUE TO stating the underlying cause lost. (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Pneumonia, Pulmonary Emboli Suspected								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (F E I T H E R N O T I F Y M E D I C A L E X A M I N E R)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day Year Hour a.m. 19 p.m.			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 1966 to Dec 30 1967 , that (I) (we) last saw the deceased alive on Dec 29 1967 , and that death occurred at 2 AM , from causes and on the date stated above								
22a. SIGNATURE Gilbert B. Gasch			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED 12-30-67		
22c. PHYSICIAN'S NAME (Type) Francis Gasch's Sons Hyattsville, Md.			22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/68		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P. C. Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.			ADDRESS			25a. RECD BY REGISTRAR JAN 4 1968		25b. REC'D. BY CLERK'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17234

1 PLACE OF DEATH o COUNTY <i>Montgomery</i>		MARYLAND		2 US AL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE <i>Maryland</i>		b COUNTY <i>Montgomery</i>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c LENGTH OF STAY IN HB <i>12 hrs</i>			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>				d. STREET ADDRESS <i>10100 Montgomery Avenue</i>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Frederick S George</i>		First	Middle	Lost	4 DATE OF DEATH <i>Dec 28</i>	Month	Day	Year
S SEX <i>Male</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>July 31, 1884</i>	9 AGE (In years last birthday) <i>83 yrs</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>No.</i>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <i>Ohio</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13 FATHER'S NAME <i>Walter S George</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Gilman</i>		Address				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16 SOCIAL SECURITY NO		17 INFORMANT		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Infarctions, pulmonary, bilateral</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>465x</i> (b) DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>12-27</i> , 19 <i>67</i> , to <i>12-28</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-28-67</i> 19 <i>67</i> , and that death occurred at <i>10501 M</i> , from causes and on the date stated above								
22a SIGNATURE <i>J Thornton Boswell, M.D.</i>		M.D.	ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22b DATE SIGNED <i>12-28-67</i>		
22c PHYSICIAN'S NAME (Type) <i>J Thornton Boswell, M. D.</i>		22d ADDRESS <i>8600 OLD GEORGETOWN RD BETHESDA, MD</i>						
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>Dec. 30, 1967</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Brainard Cemetery</i>		23d LOCAT ON (City or Town) (County) (State) <i>Cranberry, New Jersey</i>		
24 FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>		ADDRESS <i>BETHESDA, MD.</i>		25a REC'D BY REGISTRAR <i>DATE JAN 5 1968</i>		25b REGISTRAR'S SIGNATURE <i>James J. Pumphrey</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 PLACE OF DEATH a COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		b. COUNTY Montgomery	
c LENGTH OF STAY IN 1b 1 Yr. 7 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10500 Rockville Pike		d. STREET ADDRESS 10500 Rockville Pike	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) WILLIAM		First D.	Middle GRIFFITH
4. DATE OF DEATH 12 10 1967		Last 12	Month 10
5 SEX Male		Day 19	Year 67
6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
8 DATE OF BIRTH Oct. 25, 1893		9. AGE (In years last birthday) 74 yrs	
10a U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) Auto-dealer		11. BIRTHPLACE (County & State or foreign country) Washington, D. C.	
12 CIT.ZEN OF WHAT COUNTRY? U. S.			
13 FATHER'S NAME Earl Griffith		14 MOTHER'S MAIDEN NAME Elizabeth Jones	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No		16 SOCIAL SECURITY NO. 577-03-5858	
17. INFORMANT wife Mary F. Griffith		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Ventricular fibrillation		INTERVAL BETWEEN ONSET AND DEATH 15 "	
(b) DUE TO Coronary thrombosis		15-20 "	
(c) DUE TO Coronary atherosclerosis		Unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 1968 , to present, 1967 , that (I) (we) last saw the deceased alive on Dec 7 1967 , and that death occurred at 10:30 P.M. from causes and on the date stated above.			
22a SIGNATURE <i>Francis J. Murray</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
22b. DATE SIGNED 12-11-67		22d ADDRESS 1601 - 18th Street, N. W. Washington, D. C.	
23a BURIAL, CREMATON, REMOVAL (Specify) Burial		23b DATE THEREOF 12-13-67	
23c NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George County, Md.	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland	25a. REC'D BY REGISTRAR DEC 15 1967
		25b. REGISTRAR'S SIGNATURE <i>Charles J. Murray</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17239

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1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Resdence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 5 Days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Medical		e. STREET ADDRESS 4858 Battery Lane				
3. NAME OF DECEASED (Type or print) James D. HALSEY		4. DATE OF DEATH 12 June 1893	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12 June 1893			
9. AGE (In years to birthday) 74 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy	11. BIRTHPLACE (County & State or foreign country) Huntsville, Alabama	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert S. Halsey		14. MOTHER'S MAIDEN NAME Lucy Landmann				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes Not Known		16. SOCIAL SECURITY NO 214 26 3521	17. INFORMANT 4858 Battery Lane Martha T. Halsey Bethesda, Md.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 23 DEC	(County) 1967	(State) to 27 DEC 1967
21. I certify that (I) (this hospital) attended the deceased from 23 DEC 1967 , to 27 DEC 1967 , that (I) (we) last saw the deceased alive on 27 December 1967 , and that death occurred at 6:15 PM from causes and on the date stated above.				22b. DATE SIGNED		
22c. SIGNATURE E. PERLIN		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) J. SODE		22d. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, BURIAL (Specify) Burial		23b. DATE THEREOF Dec 29, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.		
24. FUNERAL DIRECTOR Joseph Gawler & sons		25. REC'D BY REGISTRAR DATE 1 JAN 3 1968	26. REGISTER'S SIGNATURE Charles J. G.			

“C. S.”

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WHEATON DOWNTIME HOME		e. STREET ADDRESS SILVER SPRING 9009 Woodland Drive	
3. NAME OF DECEASED (Type or print) LYDIA		First A.	Middle Miller
4. DATE OF DEATH Month DEC.		Last Hannick	Year 26 1967
5. SEX F	6. COLOR OR RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH FEB 14 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry MILLER		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO	
17. INFORMANT Anne M. GRIFFIN		Address 1001 1/2 S. CALIFORNIA ST. 4100 SOUTHERN RD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC VASCULAR DISEASE 2 YRS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 WKS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/7 1965 to 26 DEC 1967 , that (I) (we) last saw the deceased alive on 26 DEC 1967 , and that death occurred at 1145PM , from causes and on the date stated above.			
22a. SIGNATURE WALTER GOONH M.D.		22b. DATE SIGNED 12/27/67	
22c. PHYSICIAN'S NAME (Type) WALTER GOONH M.D.		22d. ADDRESS 2309 SHOREFIELD RD WHEATON MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/29/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Druid Ridge Cemetery 13th & 14th Sts. Wheaton, Md.	23d. LOCATION (City or Town) (County) (State) Pikesville, Md.
24. FUNERAL DIRECTOR Wm. J. Libman Son & Co. Inc.	25a. REC'D BY REGISTRAR DATE 3 1968	25b. REGISTRAR'S SIGNATURE Franklin George	

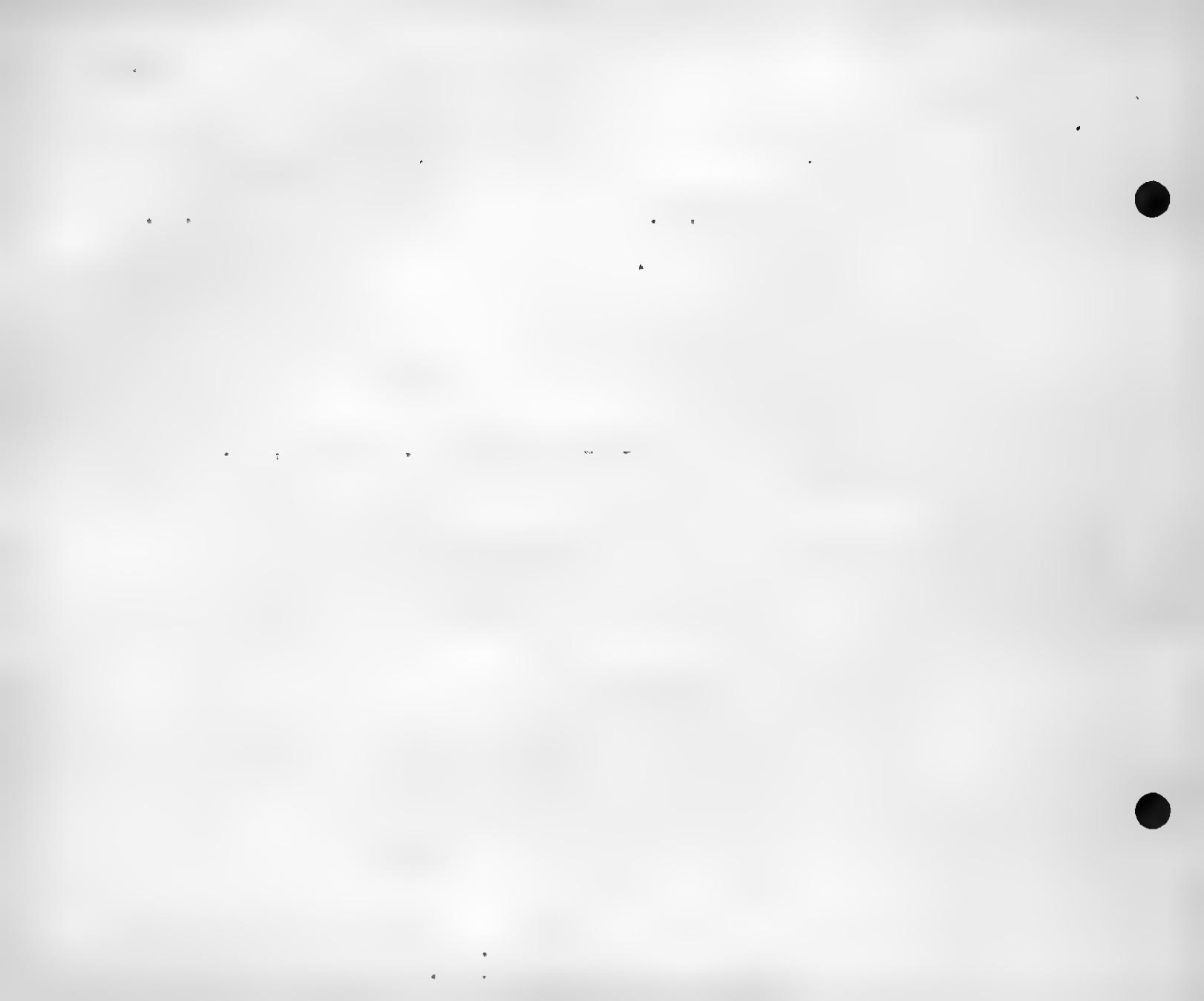


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17241

<i>Robert J. Brummond</i> <i>Medical Examiner</i> <i>County of Baltimore</i>		1242			
		1			
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.		10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.			
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND <td colspan="2" style="padding: 5px;"> 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery </td>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb <td colspan="2" style="padding: 5px;"> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest own) Silver Spring </td>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest own) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 420 University Blvd. W.		d. STREET ADDRESS 420 University Blvd. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Helen Middle A. Last Hamilton (Type or print)		4. DATE OF DEATH Month December Day 16 , Year 1967			
5. SEX Female 6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/3/04	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Baleslady		10b. KIND OF BUSINESS OR INDUSTRY <td colspan="2" style="padding: 5px;"> 11. BIRTHPLACE (County & State, or foreign country) Maryland </td>		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Charles Lechlider		14. MOTHER'S MAIDEN NAME Kelly		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO 212-24-3993		17. INFORMANT James A. Hamilton, Sr. Husband same Address # 2	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 153.8 DUE TO metastatic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO carcinoma of colon lost. (c)				19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL, BETWEEN ONSET AND DEATH	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Bilateral hydronephrosis		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rockville (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 11/1967 , to Dec. 11/1967 , that (I) (we) last saw the deceased alive on Nov. 12/11/1967 , and that death occurred at 2 P.M. , from causes and on the date stated above.				22a. SIGNATURE <i>John J. Wheeler</i>	
22c. PHYSICIAN'S NAME (Type) ARTHUR J. WHEELER		22b. DATE SIGNED 12/20/67		22d. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/20/67		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rock. Pike Rockville, Md.		25a. REC'D BY REGISTRAR DEC 21 1967 DATE	
VR A15 (4) 25M 1/67				25b. REGISTRAR'S SIGNATURE <i>Arthur J. Wheeler</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, which should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17243		17242	
<p>1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park</p>		<p>2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Howard</p>	
<p>c. LENGTH OF STAY IN 1b 14 days/18 hrs.</p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) Laurel</p>	
<p>d. STREET ADDRESS 16310 Gales St.</p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3 NAME OF DECEASED (Type or print) Ralph Johnson Harden</p>		<p>4. DATE OF DEATH December 11, 1967</p>	
<p>5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 8/12/95 9. AGE (In years at time of death) 72 yrs. IF UNDER 1 YEAR Months 6 Days 11 Hours 9 Min. 0</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. District Governor</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY Ret. Foreman</p>	
<p>11. BIRTHPLACE (County & State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME John Harden</p>		<p>14. MOTHER'S MAIDEN NAME Jane R. Thompson</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No</p>		<p>16. SOCIAL SECURITY NO 578-32-4466 17. INFORMANT Hospital Records Address 7600 Carroll Ave.</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic CA of bladder 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Carcinoma of bladder (c)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>			
<p>20a. MEDICAL CERTIFICATION</p>		<p>20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I(a)</p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of term 18)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.</p>		<p>20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or Town) Hyattsville (County) Maryland (State) M.D.</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from —, 1966, to 12-11, 1967 that (I) (we) last saw the deceased alive on 12-10 1967, and that death occurred at 7A M. from causes and on the date stated above</p>			
<p>22a. SIGNATURE Gilbert B. Ash</p>		<p>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED 12-11-67</p>	
<p>22c. PHYSICIAN'S NAME (Type)</p>		<p>22d. ADDRESS</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF 12/14/67</p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery</p>		<p>23d. LOCATION (City or Town) Hyattsville, D.C. (County) D.C. (State) M.D.</p>	
<p>24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.</p>		<p>25a. REG'D. BY REGISTRAR OCT 18 1967</p>	
		<p>25b. REGISTRAR'S SIGNATURE Charles Judge</p>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 7 & 16 Form 6196 17-168 kk

CERTIFICATE OF DEATH

17243

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
Montgomery Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Bethesda	24 days	4817 Chevy Chase Dr 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Suburban		Chevy Chase Md	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Helen	Middle Jane	Last Alice
4. DATE OF DEATH	Month Dec	Day 23	Year 1967
5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7	w		
8. DATE OF BIRTH	9. AGE (In years last birthday) 56 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
4/5/11			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (Country & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pupil Teacher Years Back	Robert	New York	in
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Charles Pachter	Margaret Lovenay		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
No	220-26-7165	Jacob Feinstein	513 S. Belmont
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>5810</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nutritional Cirrhosis</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of Vaginal Cervix Recurrent with bladder invasion</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
19			20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1967</u> to <u>Dec 1967</u> that (I) (we) last saw the deceased alive on <u>Dec 23 1967</u> , and that death occurred at <u>1153 M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>J. D. Johnson MD</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>12/24/67</u>
22c. PHYSICIAN'S NAME (Type) DR J. D. Johnson		22d. ADDRESS <u>8218 Wisconsin Ave Bethesda</u>	
23a. BURIAL CREMATION, BURIAL AND Cremated	23b. DATE THEREOF <u>12/26/67</u>	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet	23d. LOCATION (City or Town) (County) (State) N. Tonawanda New York
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home	25. ADDRESS 1331 Rockville Pike Rockville, Md.	26. REC'D BY REGISTRAR DATE DEC 29 1967	27. REGISTRAR'S SIGNATURE <u>friendly Judge</u>



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 9 Film 356177/68 kk
CERTIFICATE OF DEATH

17244

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 22 days.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburbia		e. STREET ADDRESS 5714 Crawford Drive	
3. NAME OF DECEASED (Type or print) Louisa H. Harmon		4. DATE OF DEATH Dec. 30 1967	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-78
10a. USUAL OCCUPATION (Give kind of work done during most of work no life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
13. FATHER'S NAME Unknown		11. BIRTHPLACE (County & State or foreign country) Berlin, Germany	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No, or unknown) No		16. SOCIAL SECURITY NO 225-05-4630	
17. INFORMANT Daughter - L. Smith		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) central thrombosis INTERVAL BETWEEN ONSET AND DEATH 7 d	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) (c)		DUE TO DUE TO DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) coronary artery disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1963 to 12-30, 1967 , that (I) (we) last saw the deceased alive on 12-29 1967 and that death occurred at 5:10 AM , from causes and on the date stated above.		22b. DATES GND 12-30-67	
22c. PHYSICIAN'S NAME (Type) D. L. Bucy		22d. ADDRESS 809 Veirs Mill Rd Rockville MD	
23a. BURIAL, CREMATION, Burial		23b. DATE THEREOF Jan 2 1968	
23c. NAME OF CEMETERY OR CREMATORIAL Rockville Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Mont. Md	
24. FUNERAL DIRECTOR Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md		25a. REC'D BY REGISTRAR DATE JAN 5 1968	
		25b. REGISTRAR'S SIGNATURE Charles J. Geiger	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

17245

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			b. COUNTY Montgomery		
c. LENGTH OF STAY IN 1b 14 days			c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Takoma Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospito, give street address) Washington Sanitarium and Hospital			d. STREET ADDRESS 229 Grant Avenue		
3. NAME OF DECEASED (Type or print) Edith Senora Harper			4. DATE OF DEATH Month Day Year December 10 1967		
S SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1920	9. AGE (In years lost birthday) 47 yrs
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary			11. BIRTHPLACE (County & State, or foreign country) Virginia		
13. FATHER'S NAME Clinton J. Pomeroy			12. CITIZEN OF WHAT COUNTRY? America		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 17. INFORMANT Bessie Crump Address Patient's chart		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { Peritoneitis DUE TO (b) DUE TO (c) Perforated Perforated Gastric Ulcer			INTERVAL BETWEEN ONSET AND DEATH 2 days. 2 weeks 2 weeks		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour : o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) Calmar Manor	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 25th, 1967 to Dec 10, 1967 , that (I) (we) last saw the deceased alive on Dec 10, 1967 , and that death occurred at 12 AM , from causes and on the date stated above					
22a. SIGNATURE Lyle Williams		22b. DATE SIGNED Dec 10th 1967			
22c. PHYSICIAN'S NAME (Type) Lyle Williams		22d. ADDRESS 831 University Blvde. Silver Spring			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 12, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	
24. FUNERAL DIRECTOR Arthur Walters, 254 Carroll St NW, DC		ADDRESS 254 Carroll St NW, DC		25a. REC'D BY REGISTRAR DATE DEC 15 1967	
25b. REGISTRAR'S SIGNATURE J. L. J. [Signature]					



1724

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17246

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash Sanitarium & Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>JACK</i>	Middle <i>William</i>	Last <i>HARVILLE</i>
4. DATE OF DEATH	Month <i>12</i>	Day <i>8</i>	Year <i>1967</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-8-00</i>
9. AGE (In years last birthday) <i>67 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Professor</i>	11. KIND OF BUSINESS OR INDUSTRY <i>U. S. Government</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>JACK HARVILLE</i>	14. MOTHER'S MAIDEN NAME <i>CAROLYN BELL</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NAVY</i>	16. SOCIAL SECURITY NO. <i>578-10-2167</i>	17. INFORMANT <i>Carrie Harville Adg 700 Rte 1 Dupont Ave. Kensington, Md.</i>	18. INTERVAL BETWEEN ONSET AND DEATH hours <i>24 --- hrs.</i>
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock due to</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Rupture of abdominal aortic aneurysm</i> DUE TO (c) <i>Severe aortic atherosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cirrhosis of liver</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b) <i>None</i>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 1967 to <i>present</i> , that (I) (we) last saw the deceased alive on <i>12/5/1967</i> , and that death occurred at <i>6:35 PM</i> , from causes and on the date stated above			
22a. SIGNATURE <i>John B. Umhau</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>John B. Umhau</i>	22d. ADDRESS <i>8803 Com Ave. Mayland</i>	22e. DATE SIGNED <i>12/9/67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Dec. 12, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Riverside Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Asheville, North Carolina</i>
24. FUNERAL DIRECTOR <i>John James W. Thomas</i>	24a. ADDRESS <i>8434 Georgia Ave.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE
25c. DATE DEC 13 1967			

Nov 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb years		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weston	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9217 Shelton St.		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Frank		First	Middle	Last	4 DATE OF DEATH Month Dec. 23 Day 19 Year 67
S. SEX Male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 2, 1886	9. AGE (In years last birthday) yrs 81
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY glass worker		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Frank H. McCurdy Bethesda, Md.	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					
INTERVAL BETWEEN ONSET AND DEATH 15 MIN.					
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Buckhannon (County) W. Va. (State)	
21. I certify that (I) (the hospital) attended the deceased from Dec. 22, 1967 , to Dec 23, 1967 , that (I) (we) last saw the deceased alive on Dec. 23, 1967 , and that death occurred at 8:50 A.M. from causes and on the date stated above.					
22a. SIGNATURE Leo M. Curtis		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22b. DATE SIGNED 12-23-67		
22c. PHYSICIAN'S NAME (Type) Dr. Leo M. Curtis		22d. ADDRESS 8218 WISCONSIN AVE, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-67	23c. NAME OF CEMETERY OR CREMATORIAL Heavener Cemetery	23d. LOCATION (City or Town) (County) (State) Buckhannon, W. Va.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS BETHESDA, MARYLAND	25a. REC'D BY REGISTRAR JAN 5 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17248

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After the certificate has been signed by the attending physician or attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased resided, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4016 Franklin St</u>		d. STREET ADDRESS <u>1016 Franklin St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <u>JAMES</u>	Middle <u>CLANTON</u>	4 DATE OF DEATH <u>Dec 31</u> Month <u>Dec</u> Year <u>1967</u>
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Clanton Haynes Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Flaye Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>216 40 5109</u>	
17. INFORMANT <u>William Dulin</u>		Address <u>5612 Grove St Ch, Ch, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Generalized metastatic Cancer to bone</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>177X</u> (b) <u>Primary Adenocarcinoma of the Prostate</u> DUE TO (c) <u>2 1/3 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Mount Rainier</u> (County) <u>Geo</u> (State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 to <u>Dec 31</u> , 1967, that (I) (was) last saw the deceased alive on <u>Dec 28</u> , 1967, and that death occurred at <u>8:15 AM</u> , from causes and on the date stated above.		22b. DATE SIGNED <u>12/31/67</u>	
22a. SIGNATURE <u>Edward W. Nicklas</u>		MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD W. NICKLAS</u>		22d. ADDRESS <u>4830 - V St. NW</u>	
23a. BURIAL, CREMATION, REMOVAL SPECIAL <u>Burial</u>		23b. DATE THEREOF <u>3 Jan. 1968</u> Ft Lincoln Cemetery	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or Town) <u>Mount Rainier</u> (County) <u>Geo</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Geo Md</u>	
ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	
DATE <u>JAN 5 1968</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17249

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED WITH MEDICAL EXAMINER

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital of Silver Spring		e. STREET ADDRESS 4106 Dayhill Road	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle G.	4. DATE OF DEATH Last Hendley Month 12 Day 25 Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Helper		10b. KIND OF BUSINESS OR INDUSTRY Machine shop	
13. FATHER'S NAME Howard Joseph		11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 579-03-2537	
17. INFORMANT wife Claire		Address 4106 Dayhill Rd. SSMd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>301A</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH MINUTES <i>Cerebral Vascular Accident</i>	
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <i>Emphysema, Influenza, ARTERIOSCLEROTIC Heart Disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 14 , 1964, to Dec 25, 1967 , that (I) (we) last saw the deceased alive on 12/21 1962, and that death occurred at 9:00 AM , from causes and on the date stated above			
22a. SIGNATURE <i>Raymond T. Benack</i>			
22c. PHYSICIAN'S NAME (Type) Raymond T. Benack MD		MD ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
22d. ADDRESS 4115 Colie Drive, Wheaton MD		22b. DATE SIGNED 12/25/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-28-67	
23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George County, Md.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 29 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE	



1



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17250

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon from pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 1/2 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN MD 1-1/2 months		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Mt. Rainier				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 3412 Newton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Gertrude		First	Middle	Lost	4. DATE OF DEATH Dec. 4, 1967	Month	Day	Year
S SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/17	9. AGE (in years lost birthday) 50 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Beautician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Saltville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Albert Cahill				14. MOTHER'S MAIDEN NAME Florence				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. W W II 226 10 0085		17. INFORMANT Hospital records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1602		DUE TO Conditions, if any which gave rise to immediate cause (a). Stating the underlying cause lost		INANITION - DEHYDRATION		INTERVAL BETWEEN ONSET AND DEATH 1 week		
(b)		DUE TO		CARCINOMATOSIS				
(c)		DUE TO		CARCINO MA (MAXILARY SINUS 6 months)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that (1) XXXXXX attended the deceased from 1935 , 19, to Dec. 4, 1967 that (1) (we) last saw the deceased alive on Dec. 4, 1967 , and that death occurred at M. from causes and on the date stated above.								
22a. SIGNATURE Benjamin Miller		MD ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Dec. 5, 1967		
22c. PHYSICIAN'S NAME (Type) Benjamin Miller, M. D.		22d. ADDRESS 3824 34th St., Mt. Rainier, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-1967		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Elizabeth Cemetery		23d. LOCATION (City or Town) (County) (State) Saltville, Virginia		
24. FUNERAL DIRECTOR Nalley Funeral Home		ADDRESS Mt Rainier, Md.		25a. REC'D BY REGISTRAR DATE DEC 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1636
CERTIFICATE OF DEATH

17251

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Althea Woodland Nsg. Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Edna</i>	Middle <i>E.</i>	Last <i>Hickey</i>
4. DATE OF DEATH	Month <i>12</i>	Day <i>28</i>	Year <i>1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-21-1882</i>
9. AGE (In years last birthday) <i>85</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>Elisha E. Berry</i>		
14. MOTHER'S MAIDEN NAME <i>Edna Cork</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>579-60-1365</i>	17. INFORMANT <i>B. Greenley</i>	Address <i>811 Houston Takoma Park, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic uremia</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Atherosclerotic vascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>-</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>-</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>
20f. (City or town) <i>-</i>		(County) (State) <i>-</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>July 15, 1967</i> , to <i>Dec. 21, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec. 21, 1967</i> , and that death occurred at <i>44 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F. Mc Mahon</i>		22b. DATE SIGNED <i>12-21-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Thomas F. Mc Mahon</i>		22d. ADDRESS <i>3000 Columbia Gardens Cem.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>12/30/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Columbia Gardens Cem.</i>
24. FUNERAL DIRECTOR <i>The J.H. Hines C. 2901 14th St. N.W.</i>		ADDRESS <i>-</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
			DATE <i>JAN 3 1968</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17252

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH <i>Montgomery County Home</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
a. COUNTY <i>FARLAND & NURSING</i>		d. STATE <i>PARRY, OHIO</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>		c. LENGTH OF STAY IN LB <i>Age: 9m, 10days</i>	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hospital - 2171 Buckland Rd St. Spn, MD</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WHEATON, MD</i>	
3. NAME OF DECEASED (Type or print) <i>Laura K. Hicks</i>		d. STREET ADDRESS <i>12078 Cuttehill Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>15 June 1875</i>
9. AGE (In years last birthday) <i>92 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SECRETARY (RETIRED) TREASURY DEPT.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Treasury Dept.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>DENN KIEFER</i>		14. MOTHER'S MAIDEN NAME <i>BRIDELIA PRATT</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>WARREN D. HICKS - SAME AS. 2A-B-C-D.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Heart failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. <i>Coronary artery disease</i> DUE TO (b) <i>Generalized arterosclerosis</i> DUE TO (c) <i> </i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i> </i>
20f. (City or town) <i> </i> (County) <i> </i> (State) <i> </i>		21. I certify that (I) (this hospital) attended the deceased from <i>8-20-65</i> , 19 <i>65</i> , to <i>12-4</i> , 19 <i>67</i> , that (II) (we) last saw the deceased alive on <i>12-4-67</i> 19 <i>67</i> , and that death occurred at <i>5 P.M.</i> from causes and on the date stated above	
22a. SIGNATURE <i>Morris Perry</i>		22b. DATE SIGNED <i>12-4-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>MORRIS PERRY</i>		22d. ADDRESS <i>11602 Georgia Ave Silver Spring MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12/7/1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>FOUNTAIN MORT. CO.</i>
23d. LOCATION (City or Town) <i>FOSTORIA, OHIO</i>		(County) <i> </i> (State) <i> </i>	
24. FUNERAL DIRECTOR <i>W.W. CHAMBERS INC. SILVER SPRING MD</i>		25a. ADDRESS ADDRESS <i> </i>	
25b. REC'D BY REGISTRAR DATE <i>DEC 7 1967</i>		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHEVY CHASE Bethesda</i>		c. LENGTH OF STAY IN 1b <i>4 mos 21 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>BETHESDA SILVER SPRING NURSING HOME</i>		e. STREET ADDRESS <i>4601 Diamond Ave.</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>May</i>	Middle <i>BAKER</i>	Last <i>HIGHSAW</i>
4. DATE OF DEATH	Month <i>12</i>	Day <i>28</i>	Year <i>1967</i>
5. SEX <i>FE</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>5-3-85</i>	9. AGE (In years last birthday) <i>82 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>- - -</i>	11. BIRTHPLACE (County & State, or foreign country) <i>KANSAS</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Moses Baker</i>	14. MOTHER'S MAIDEN NAME <i>Sarah Jane Willson</i>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>	16. SOCIAL SECURITY NO. <i>---</i>	17. INFORMANT <i>PATIENT'S CHART -</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>493X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b) Pneumonia</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriosclerosis</i>			19. WAS A POSTMORTEM EXAMINATION PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>July 1967, to Dec. 28, 1967, that (I) we lost saw the deceased alive on Dec. 28 1967, and that death occurred at 3:50 PM, from causes and on the date stated above</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>2001 I ST, N.W., WASHINGTON, DC</i>
20f. (City or town) <i>Memphis, Tenn.</i>		(County) <i>Tenn.</i>	(State) <i>Memphis, Tenn.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>July 1967</i> , to <i>Dec. 28, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec. 28 1967</i> , and that death occurred at <i>3:50 PM</i> , from causes and on the date stated above		22d. DATE SIGNED <i>Dec. 28, 1967</i>	
22e. SIGNATURE <i>Thomas L. Hartman</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>2001 I ST, N.W., WASHINGTON, DC</i>
22e. PHYSICIAN'S NAME (Type) <i>Thomas L. HARTMAN</i>		23d. LOCATION (City or Town) <i>Memphis, Tenn.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>12-29-1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Forest Hill Cemetery</i>
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Wash. D.C.</i>		25a. ADDRESS <i>5130 Wisconsin Ave. N.W. Wash. D.C.</i>	25b. REC'D BY REGISTRAR <i>JAN 3 1968</i>
		25c. REGISTRAR'S SIGNATURE <i>Charles J. Gause</i>	



Items 18-21 Film #396 MARYLAND STATE DEPARTMENT OF HEALTH
1-4-6 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17254

FOR STATE
HEALTH DEPT.

1-4-6 mt
PMS-Bal
1



If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Bal. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE WASHINGTON b. COUNTY D.C.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 8hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL			d. STREET ADDRESS 3820 8th Street, N.W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) ARLANO		First	Middle	Last	4 DATE OF DEATH HILL	Month 12	Doy 17	Year 1967
S SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/6/30	9 AGE (In years last birthday) 17 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen helper		Job. K ND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Wash.D.C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Arlando Hill, Sr.			14. MOTHER'S MAIDEN NAME Sallie Brown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOC. SECUR. NO.		17. INFORMANT Sallie Brown			Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Exsanguination Hemorrhage due to Gunshot Wound of Left Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) and Heart. DUE TO and Heart.								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18). Fellow employee loading revolver and it discharged bullet hitting deceased in chest.						
20c. TIME OF INJURY Month Day Year 1:10 pm 12 17 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, off se bldg., etc.) Restaurant		20f. (City or town) (County) (State) Wheaton Mont Md		
21. I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Read M.D. Wheaton CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Belden R. Read M.D. Wheaton ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address: Belden Read, M.D., Wheaton, Maryland								
22. DATE SIGNED Dec. 17, 1967								
23a. BURIAL, CREMATION REMOVAL, (Specify) 1/22/68		23b. DATE THEREOF 1/22/68		23c. NAME OF CEMETERY OR CREMATORI Arlington Nat.		23d. LOCATION (City or Town) (County) (State) H. Meyer Va		
24. FUNERAL DIRECTOR Rhine's Funeral Home		ADDRESS 3015-12 st		25a. REC'D BY REGISTRAR DEC 27 1967			25b. REGISTRAR'S SIGNATURE J. E. Judge	
VR A15ME (5) 6M 1/67								



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <i>D.C.</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c LENGTH OF STAY IN 16 <i>37 days.</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
3 NAME OF DECEASED (Type or print) <i>Edward E. Hill</i>		First <i>E</i>	Middle <i>Edward</i>
4 DATE OF DEATH Month <i>Dec.</i>	Month <i>7</i>	Day <i>19</i>	Year <i>67</i>
S SEX <i>M.</i>	6 COLOR OR RACE <i>Negro</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Soldier</i>		9. DATE OF BIRTH <i>2/20/92</i>	
10b. KIND OF BUSINESS OR INDUSTRY		9 AGF years (day) yrs <i>75</i>	
11. BIRTHPLACE (City & State, or foreign country) <i>Spider Ga</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alf. Hill</i>		14. MOTHER'S MAIDEN NAME <i>Lesa?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-03-4479</i>	
17. INFORMANT <i>Hs. Chart</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Failure of the Circulation</i>			
DUE TO (b) <i>Carcinoma of Prostate with metastases to bone of vertebra + ribs</i>			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>6 month</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7:50 P.M.</i>
20f. (City or town) <i>Baltimore</i>		(County) <i>MD</i>	
		(State) <i>MD</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 20 1967</i> to <i>Dec. 7, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 7 1967</i> , and that death occurred at <i>7:50 P.M.</i> from causes and on the date stated above			
22a. SIGNATURE <i>J. H. Hill</i>		22b. DATE SIGNED <i>Dec 13 1967</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/12/67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Serenity Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore</i>	
24. FUNERAL DIRECTOR <i>R.N. Horton Co. 1324 14th St. NW</i>		25a. REGD BY REGISTRAR REGISTRAR'S SIGNATURE <i>DEC 13 1967</i>	
ADDRESS		DATE <i>DEC 13 1967</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from page 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY MONTGOMERY						2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park						b. COUNTY Montgomery							
c. LENGTH OF STAY IN lb 8hrs./55min.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital						d. STREET ADDRESS 7311 Baltimore Ave.							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)			First Mary	Middle Alexandria	Last Hotchkiss	4. DATE OF DEATH Month December Day 6 , Year 1967							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-2-81		9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State, or foreign country) Pa.					
13. FATHER'S NAME Lewis Moore				14. MOTHER'S MAIDEN NAME Mary Becker				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No				16. SOCIAL SECURITY NO 290-10-7783				17. INFORMANT Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST								Address 7600 Carroll Ave.					
604X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				DUE TO (b) C-RRM NEG SEPSIS & SHOCK				INTERVAL BETWEEN ONSET AND DEATH 24hr					
				DUE TO (c) URINARY TRACT INRCT				24hr					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CVA with indwelling catheter													
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) 12-5-67									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJRY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 831 UNIVERSITY BLVDE.		(County) SILVER SPRING MD.		(State)	
21. I certify that (1) (this hospital) attended the deceased from 12-5-67 to 12-6-67 , that (1) (we) last saw the deceased alive on 12-6-67 , and that death occurred at 255A M , from causes and on the date stated above													
22a. SIGNATURE J. L. Ford													
22c. PHYSICIAN'S NAME (Type) JOHN L. FORD				22d. ADDRESS 831 UNIVERSITY BLVDE.				22e. DATE SIGNED 12/6/67					
23a. BURIAL, CREMATION, REMOVAL (Check)		23b. DATE THEREOF 12/11/67		23c. NAME OF CEMETERY OR CREMATORIUM FORT LINCOLN CEM.		23d. LOCATION (City or Town) BELMONT PARK MD.		(County) MONTGOMERY		(State) MD			
24. FUNERAL DIRECTOR W. W. Chambers & Sonnelor Mel		ADDRESS		25a. REC'D BY REG STRR DATE DEC 11 1967		25b. REGISTER'S SIGNATURE Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Page 4 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If you do not have a funeral director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH											
17258					17257						
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>47 years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>615 Hollywood Street</u>					d. STREET ADDRESS <u>615 Hollywood Street</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED First <u>Alfred</u> Middle <u></u> Last <u>Houston</u>				4. DATE OF DEATH <u>December 21 1967</u>		Month <u>December</u> Day <u>21</u> Year <u>1967</u>					
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 June 1885</u>		9. AGE (In years last birthday) <u>82 yrs.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>J.C. Flood Co.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert Houston</u>					14. MOTHER'S MAIDEN NAME <u>Mary Keating</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>1912-1919</u>			16. SOCIAL SECURITY NO <u>213-58-7931</u>		17. INFORMANT <u>Silver Spring, MD</u> <small>Address</small> <u>Mrs. Blanche M. King 215-Hol'lywood Avenue</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) <u>Senile myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>arteriosclerosis</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Silver Spring</u> <u>Montgomery</u> <u>MD</u>				
21. I certify that (I) (this hospital) attended the deceased from <u>year</u> , 19 <u>67</u> , to <u>11-20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-20</u> , 19 <u>67</u> , and that death occurred at <u>11:35 PM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>John N. Andrews</u>					22b. DATE SIGNED <u>12-22-67</u>						
22c. PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>			22d. ADDRESS <u>101 Colesville Rd Silver Spring Maryland</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 26. 1967</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Gate Of Heaven</u>			23d. LOCATION (City or Town) <u>Silver Spring</u> , Maryland				
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		ADDRESS <u>1111 E. Grey Inc. 8434 Ga. Ave. Sil Sp., MD</u>					25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John N. Andrews</u>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b Kensington Garden Santorium		b. COUNTY Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Nursing Home			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase,		
3. NAME OF DECEASED (Type or print) ELLA STEARNS HUMBLE			d. STREET ADDRESS 4898 Chevy Chase Blvd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Month Day Year December 27, 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 26, 1879	9. AGE (In years In birthday) 88 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Lawyer		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Massachusetts	
13. FATHER'S NAME Walter H. Stearns, Jr.			14. MOTHER'S MAIDEN NAME Jessie L. Bowker		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 022-20-4168		17. INFORMANT John S. Humble-Son 5-Colonial Way Address Hampton, N.J.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4+00 DUE TO Bilateral Broncho pneumonia INTERVAL BETWEEN ONSET AND DEATH 6 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Heart Failure 2 Weeks (c) Arteriosclerotic Heart Disease 5 Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) John S. Humble-Son 5-Colonial Way (County) Hampton (State) N.J.	
21. I certify that (I) (this hospital) attended the deceased from 17 Dec. 1967 to 27 Dec. 1967 , that (I) (we) last saw the deceased alive on 26 Dec. 1967 , and that death occurred at 8:05 P.M. from causes and on the date stated above.					
22a. SIGNATURE <i>Horace H. Custis, Jr.</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-28-1967		
22c. PHYSICIAN'S NAME (Type) Horace H. Custis, Jr.		22d. ADDRESS 1852 Columbia Road, N.W. Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-28-1967	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) Suitland, Md. (County) Md. (State) U.S.A.	
24. FUNERAL DIRECTOR Joseph Gowler's Sons, Inc.		ADDRESS 5130 Wisconsin Ave. N.W. Wash. D.C.	25a. DATE BY REGISTRATION 12-28-1968	25b. REGISTRATION NUMBER 1234567890	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17259

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form P.M. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transmit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Perryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>730 West 5th St</i>		c. LENGTH OF STAY IN lb <i>40 ft.</i>	
d. CITY OR TOWN (if outside corporate limits, write RJRAL and give nearest town) <i>730 West 5th St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Tuberculosis</i>		d. STREET ADDRESS <i>4526 Rosedale Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Addie</i>		4. DATE OF DEATH Month Day Year <i>Dec. 30 1967</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
9. AGE (in years last birthday) yrs <i>78</i>		10. DATE OF BIRTH <i>Dec. 18, 1889</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Arthur Holliday</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth (Unknown)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <i>No</i>		16. SOCIAL SECURITY NO <i>700</i>	
17. INFORMANT <i>Mariam Greenwood</i>		18. ADDRESS <i>10900 Rockville Rd Bethesda Md.</i>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last) (b) DUE TO (c)		20. INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
Coronary Insufficiency Acute - Cardio Vascular Disease Years.			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Bethesda, Md.</i>	
EXAMINER'S NAME (Type) <i>John G Ball</i>		22. DATE SIGNED <i>12/30/67</i>	
23a. BURIAL, CREMATION, Bury (check) Cremate (check)		23b. DATE THEREOF <i>3 Jan 1968</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Cemetery</i>
23d. LOCATION (City or Town) <i>Rockville, Mont. Md</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>		25a. ADDRESS <i>7557 Wisconsin Ave</i>	25b. REC'D BY REGISTRAR <i>JAN 5 1968</i>
		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



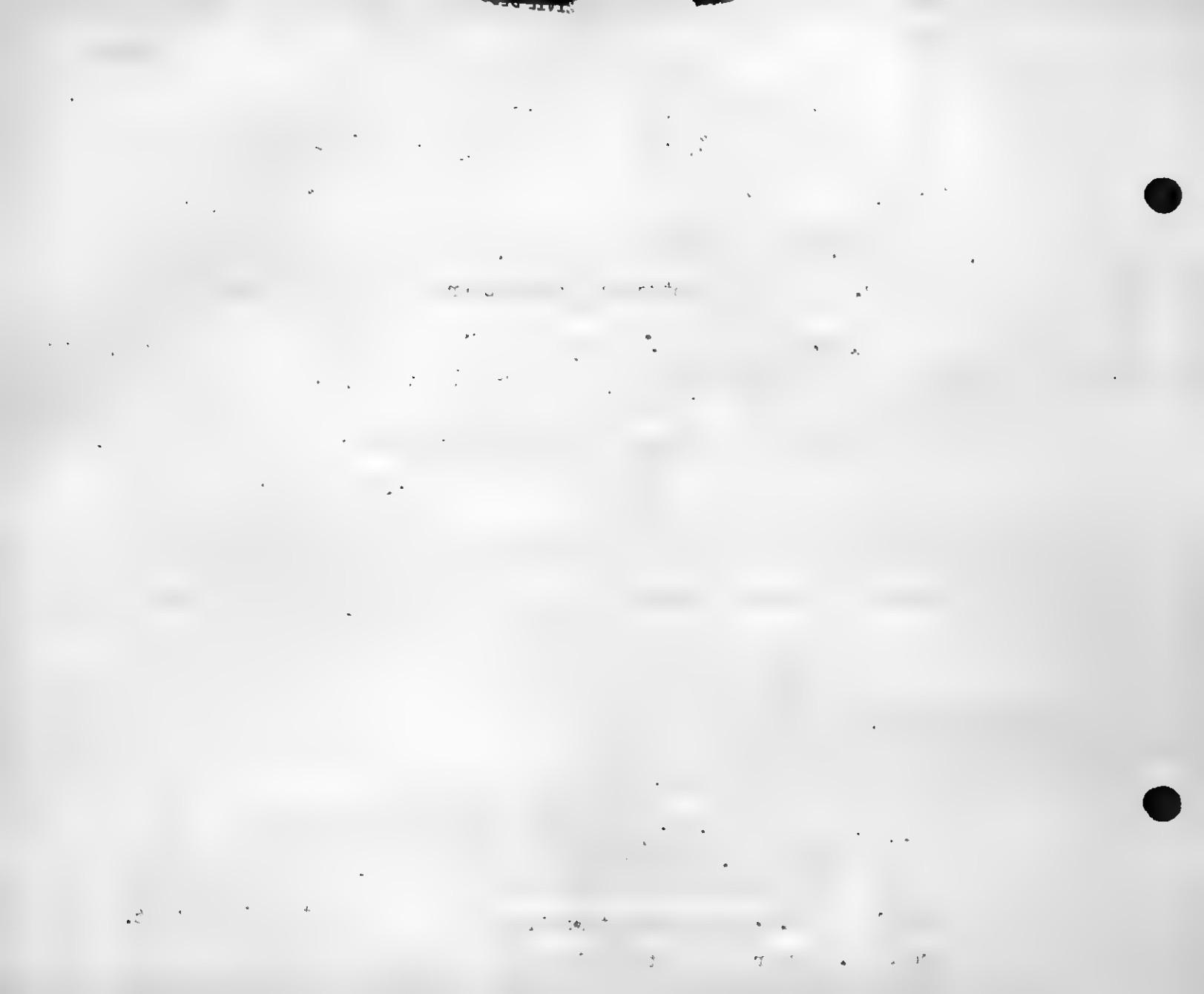
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH 12 Month 24 Day 67 Year	2b. HOUR 3:40A-M	
ELIZABETH (NMN) INCHES							
3. SEX FEMALE		4 RACE WHITE	5. DATE OF BIRTH SEPT 11, 1886		6. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF JUNIOR 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) CANADA		7b. CITIZEN OF WHAT COUNTRY? 245	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Hall San.		12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Unknown		
14. FATHER'S NAME First Richard T		Middle	Last	15. MOTHER'S MAIDEN NAME First Elizabeth	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 577-34-1202		17. INFORMANT Robert Inches	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4221 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost <u>ARTERIOSCLEROTIC HEART DISEASE</u> (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Sensitivity</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 26, 1966</u> , to <u>DECEMBER 24 1967</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 24 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Henry M. Lowden MD</u>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 12-24-67			
22d. PHYSICIAN'S NAME (Type) Henry M. Lowden		22e. ADDRESS 5206 Normandy Dr. Cherry Chase Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 28 1967	23c. NAME OF CEMETERY OR CREMATORIUM Laytonsville		23d. LOCATION (City or Town) Laytonsville	(County) Mont.	(State) Md
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville Md	25a. REC'D. BY REGISTRAR DATE JAN 2 1968		25b. REGISTRAR'S SIGNATURE Francis Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		
<i>Montgomery Maryland</i>		<i>District of Columbia</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
<i>Bethesda Md days.</i>		<i>Washington 47-3</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address)		d. STREET ADDRESS <i>3601 - Cordova Ave. N.W. #806</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
<i>Edwin Warley James</i>				
4. DATE OF DEATH	Month	Day	Year	
<i>Dec. 22 1967</i>				
S. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH DIVORCED <input type="checkbox"/>	
<i>Male</i>	<i>White</i>		<i>Oct. 17 1877</i>	
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min	
<i>90 yrs</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
<i>Civil engineer</i>	<i>Public roads New York</i>			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
<i>Edwin Thomas James</i>	<i>Edna Warley</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	Address	
<i>No</i>	<i>879-44-6038</i>	<i>Alice James</i>	<i>Hazeltine Apartments, Chevy Chase, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	INTERVAL BETWEEN ONSET AND DEATH			
<i>Peritonitis</i>	<i>5703</i>	<i>going from last</i>	<i>due to per.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	(c)		
<i>Int. Obstruction</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
<i>Dec 22 1967</i>				
21. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , to <i>Dec 22, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 22 1967</i> , and that death occurred at <i>6:50 P.M.</i> from causes and on the date stated above.				
22a. SIGNATURE	22b. DATE SIGNED <i>Stewart Clapp</i> <i>Dec 22 1967</i>			
22c. PHYSICIAN'S NAME (Type)	MD	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS
<i>Stewart Clapp M.D.</i>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town)	(County) (State)
<i>CREMATION</i>	<i>Dec 24, 1967</i>	<i>Cedar Hill Crematory</i>	<i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR	ADDRESS	25c. REC'D BY REGISTRAR DATE	25b. MGR STRR'S SIGNATURE	
		<i>JAN 3 1968</i>	<i>Charles J. Gause</i>	

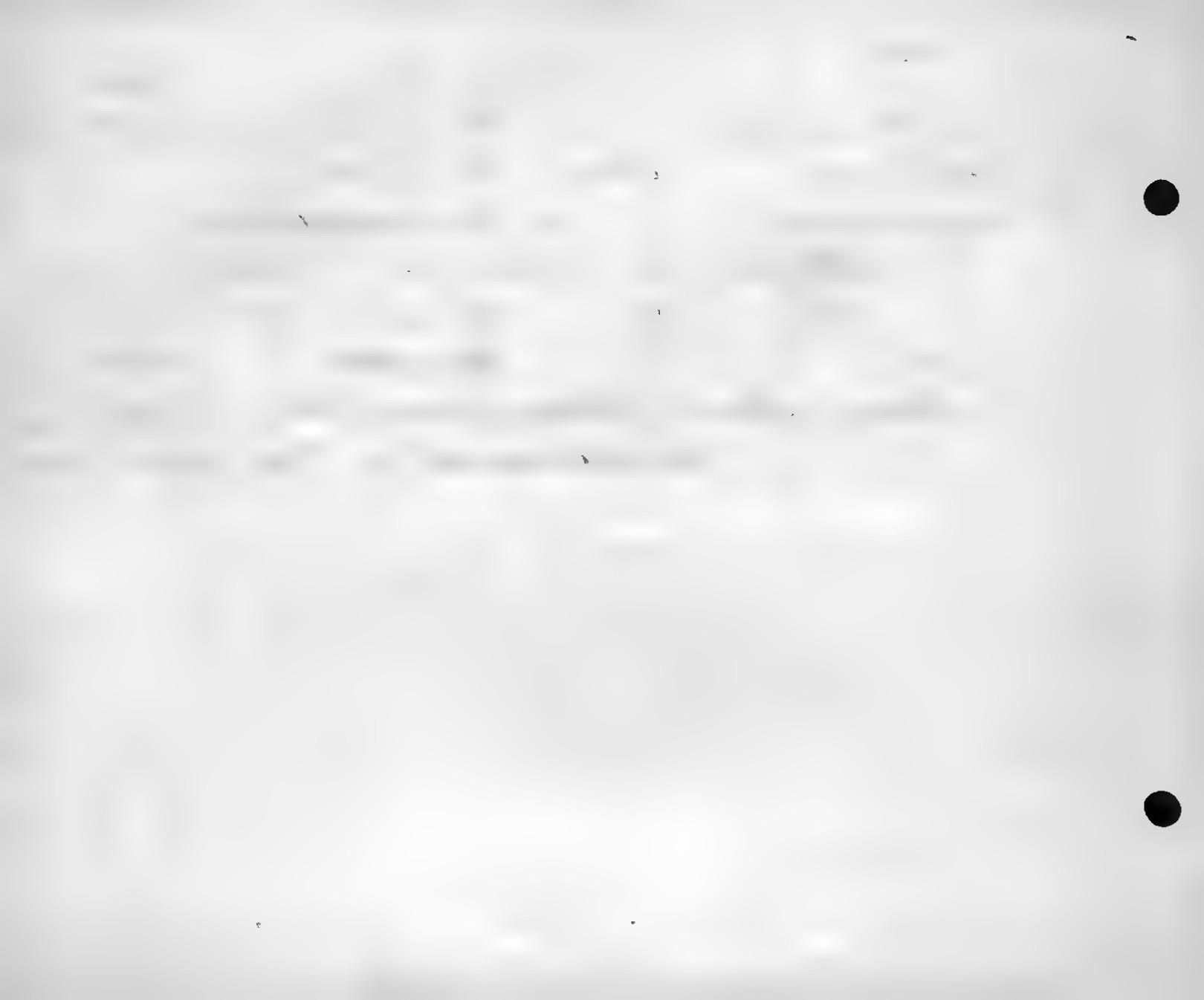


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this cert. fice has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased resided, if in institution Residence before admission) a STATE <i>Maryland</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c LENGTH OF STAY IN lb <i>67 days</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d STREET ADDRESS <i>7109 Fairly Road</i>	
3 NAME OF DECEASED (Type or print) <i>Gladys J. Jenkins</i>		First <i>J</i>	Middle <i>Jenkins</i>
4 DATE OF DEATH Month <i>Dec.</i>		Month <i>2</i>	Day Year <i>1967</i>
S. SEX <i>F white</i>	6 COLOR OR RACE <i>No</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. US-AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>No</i>		9. DATE OF BIRTH <i>11/16/85</i>	
10b KIND OF BUSINESS OR INDUSTRY <i>No</i>		11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>	
13. FATHER'S NAME <i>Gideon Samuel Palmer</i>		14. MOTHER'S MAIDEN NAME <i>Mary Laura O'Neill</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or withdrawn) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>210-46-1177</i>	
17. INFORMANT <i>Susan J. Hale</i>		Address <i>39 Jan Ave Pittsburgh, Pa.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4221</i>		Palmonitis Myocardial Decomp. with edema. INTERVAL BETWEEN ONSET AND DEATH <i>37 days.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause DUE TO (b) DUE TO (c)		Uremia, terminal, severe Arteriosclerosis, generalised. 2 months.	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Adenocarcinoma, metastatic from left breast</i>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) —		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B) —	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d INJURY OCCURRED While at work Not While at work <input type="checkbox"/> <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office building, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1967</i> to <i>12-7-67</i> , that (I) (we) last saw the deceased alive on <i>12-7-67</i> , and that death occurred at <i>7:55 P.M.</i> from causes and on the date stated above.			
22a SIGNATURE <i>Susan Hale</i>		22b DATE SIGNED <i>12-7-67</i>	
22c PHYSICIAN'S NAME (Type) <i>Stewart C. Lapp M.D.</i>		22d ADDRESS <i>4740 Cheyenne Dr., Bronx, New York</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>12-11-67</i>	
23c NAME OF CEMETERY OR CREMATORIAL <i>Hoodlawn Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Bronx, New York</i>	
24 FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a REC'D BY REGISTRAR DATE <i>DEC 11 1967</i>	
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17263

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN 1b 23 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		e STREET ADDRESS 801 Potomac Avenue	
3 NAME OF DECEASED (Type or print) Margaret		First Margaret	Middle Sarah
Last Jenkins		4 DATE OF DEATH December	Month 4
5 SEX Female		6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8 DATE OF BIRTH January 31, 1891		9 AGE (in years last birthday) 76 yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY --	
11 BIRTHPLACE (County & State, or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Green		14. MOTHER'S MAIDEN NAME Margaret Kellum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Not available	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 9 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic coronary artery disease		Unknown	
DUE TO (b) Arteriosclerotic coronary artery disease			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of vulva - bilateral radical groin dissection (11 days)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) White at work	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Snelling Funeral Home
20f. (City or town) Portsmouth		(County) Virginia (State)	
21. I certify that Dr. Alfred S. Ketcham attended the deceased from November 11, 1967 , to December 4, 1967 , that he last saw the deceased alive on December 4, 1967 , and that death occurred at 6:45 A.M. from causes and on the date stated above.		22b. DATE SIGNED 4 December 1967	
22a. SIGNATURE Dr. Alfred S. Ketcham (Sign. below)		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 4 December 1967
22c. PHYSICIAN'S NAME (Type) Charles Judge		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12/4/67	23c. NAME OF CEMETERY OR CREMATORIUM Snelling Funeral Home
23d. LOCATION (City or Town) Portsmouth, Virginia		(County) Virginia (State)	
24. FUNERAL DIRECTOR J. Wm Lee & Sons, 300 4th St, Wash, D.C.		ADDRESS DECEMBER 8, 1967	25a. REC'D BY REGISTRAR Charles Judge
			25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to removal, retention, removal, retransit, reburial, reinterment, or removal from the hospital or attending physician.

265		17264											
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SHARON Nsg Home					e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Minnie		First	Middle	Last	4. DATE OF DEATH Dec 3		Month	Day	Year				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	8. DATE OF BIRTH 3/14/1867	9. AGE (In years last birthday) 100	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Richmond, Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Lane Perry		14. MOTHER'S MAIDEN NAME Hucinda Bradley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 220-57-12417		17. INFORMANT Leslie E. Johnson		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 471 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Sensitivity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fractured RT hand		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Nsg Home		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4/22 , 19 66 to 12/3 , 19 67 that (I) (we) last saw the deceased alive on 12/3/1967 , and that death occurred at 3 PM , from causes and on the date stated above.	
22a. SIGNATURE Olive Johnson		22b. MEDICAL CERTIFICATION C.H. Liggett MD		22c. ATTENDING PHYS <input checked="" type="checkbox"/>		22d. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22e. ADDRESS JANET SPRING, MD.		22f. DATE SIGNED 12/3/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THIRFOF 11/9/67		23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery		23d. LOCATION (City, State) Hanover, Kan County, Kansas							
24. FUNERAL DIRECTOR Robert Pumphrey Funeral Home, Rockville, Md		25a. ADDRESS Robert Pumphrey Funeral Home, Rockville, Md		25b. REC'D BY REGISTRAR DATE DEC 8 1967		25c. REGISTRAR'S SIGNATURE Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17265

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED BY MEDICAL EXAMINER

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 16 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Washington D.C.	
3 NAME OF DECEASED (Type or print) Daisy Irene		First J Middle Johnstone	4 DATE OF DEATH Dec. 20 1967
5 SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/1880
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (in years last birthday) 87 yrs.
11 BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Boyer		14 MOTHER'S MAIDEN NAME Sylindia Bright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Nursing Home Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1992 DUE TO Branchopneumonia. INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Metastatic carcinoma. (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (Cty or town) Dec. 19, 1967 (County) Dec. 19, 1967 (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec. 19, 1967 to Dec. 19, 1967 , that (I) (we) last saw the deceased alive on Dec. 20, 1967 , and that death occurred at 500A.M. from causes and on the date stated above.			
22a SIGNATURE Myron L. Lenkin		22b DATE SIGNED 12-20-67	
22c PHYSICIAN'S NAME (Type) MYRON L. LENKIN		22d ADDRESS 2500 Shorefield Road Wheaton, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12-22-67	23c NAME OF CEMETERY OR CREMATORIUM Arlington Natl. Cem.
23d LOCATION (Cty or Town) Arlington (County) Virginia (State)		23e REG'D BY REGISTRAR DEC 26 1967 (Signature) Charles J. [Signature]	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS	25b REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

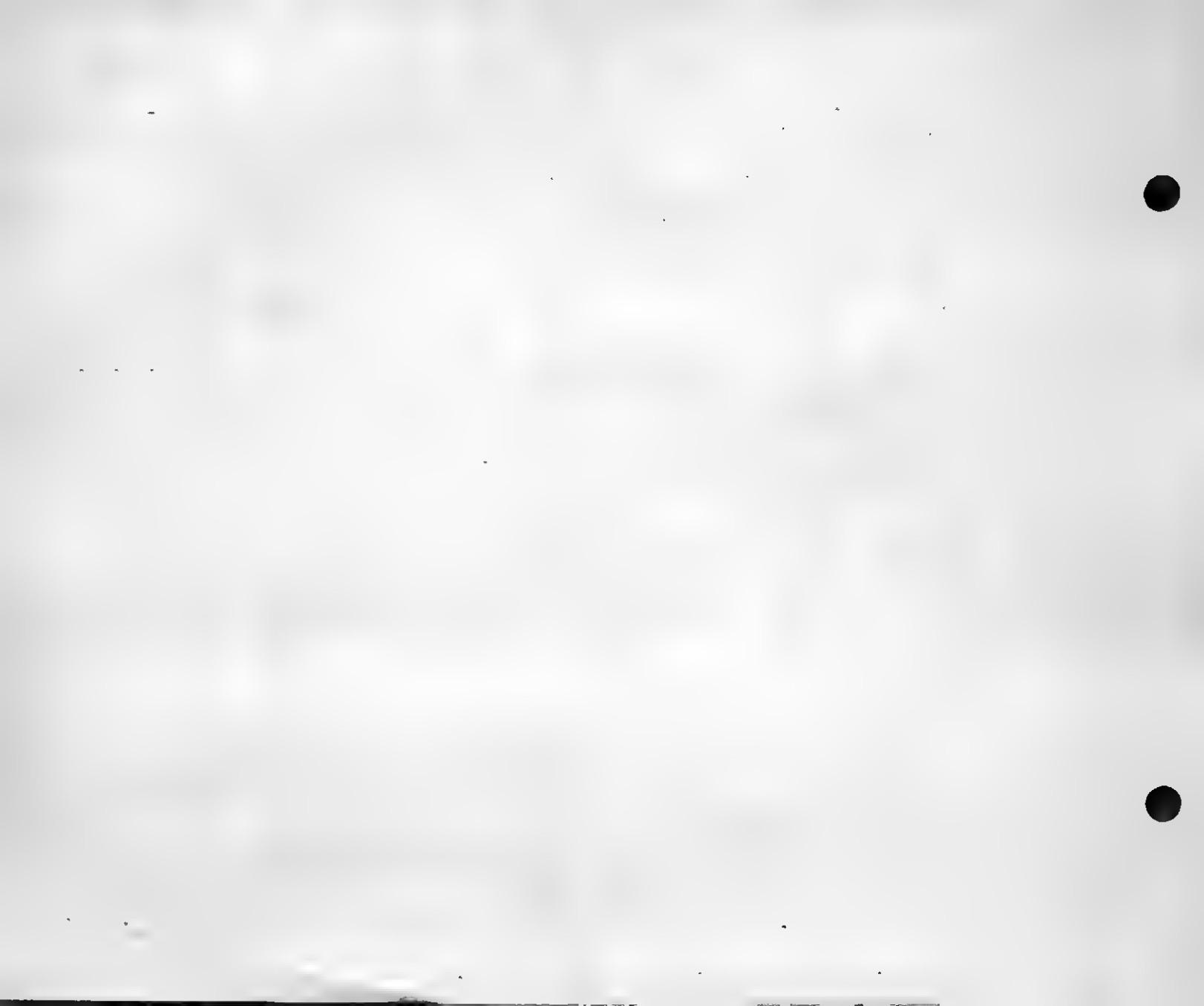
17261

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>8215 Cedar St.</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. San & Hospt.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>ALINE D. KEISER</i>		First	Middle	Last	4. DATE OF DEATH Month <i>12</i>	Month <i>12</i>	Day <i>27</i>	Year <i>1967</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>1889</i>	9. AGE (In years last birthday) <i>78 yrs.</i>	F. UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Our home</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Frank Davis</i>				14. MOTHER'S MAIDEN NAME <i>Betty Grove</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>Mr. Pott, Bridge</i>		Address <i>Edgewater, Md. 20704</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Subarachnoid Hemorrhage</i>		DUE TO <i>b) Hypertensive Cardiovascular Disease</i>				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost</i>		DUE TO <i>c)</i>						
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Belden R. Peabody</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <i>BELDEN R. PEAP, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 20, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Saint Louis Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince George's Co., Md.</i>		
24. FUNERAL DIRECTOR <i>John Blum</i>		24a. ADDRESS <i>1725 1/2 Franklin Avenue, Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

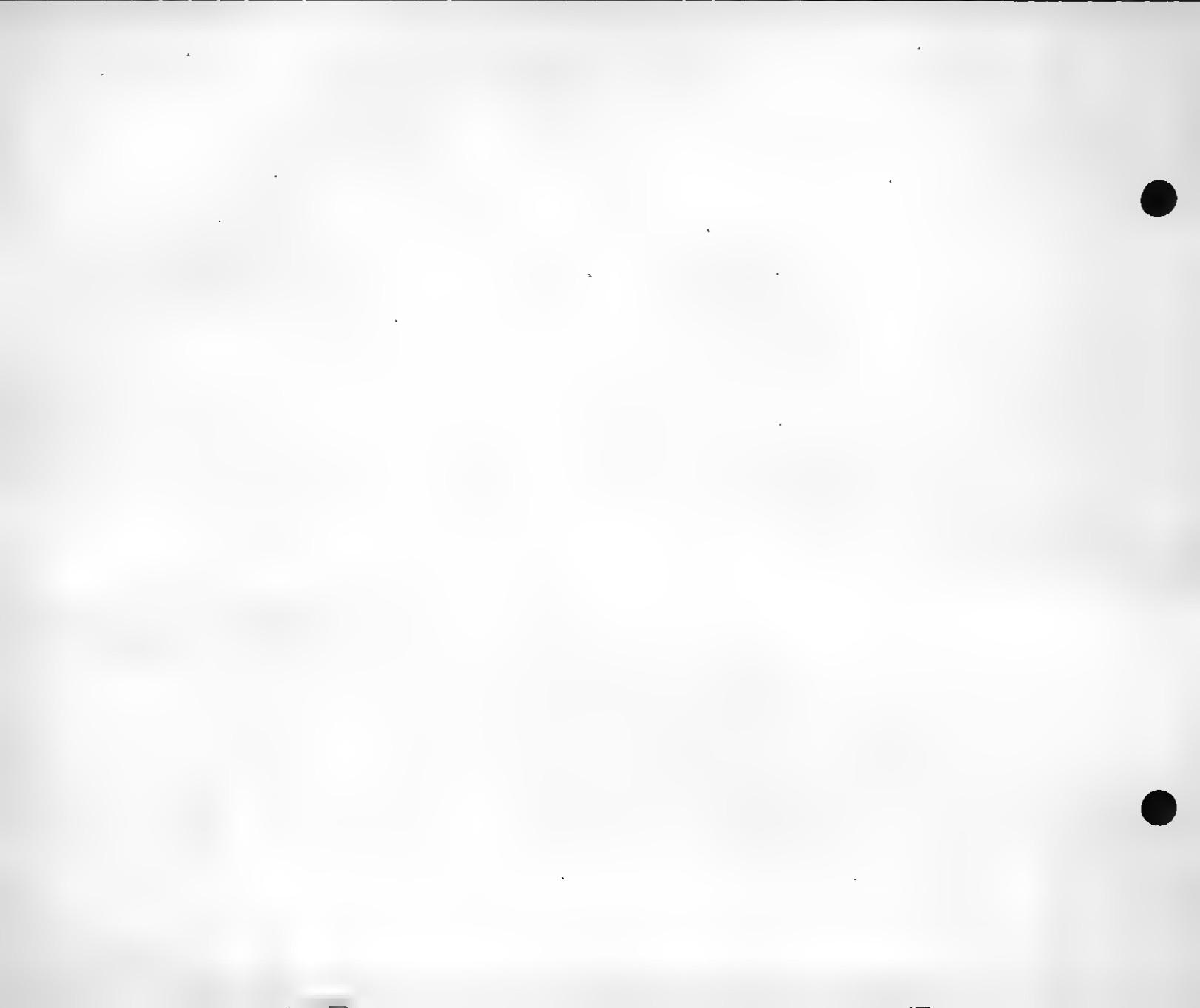
1
26
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Part 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17267

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased resided, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>9 mos.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1220 East West Highway</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FAY BRICKMAN KEMELHOR</i>		First	Middle
4. DATE OF DEATH <i>DEC. 4 1967</i>	Month	Day	Year
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>CAUC</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12-24-1892</i>
10. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		9. AGE (In years last birthday) <i>75 yrs</i>	
11. BIRTHPLACE (State or foreign country) <i>POLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. (NAT.)</i>	
13. FATHER'S NAME <i>PAUL BRICKMAN</i>		14. MOTHER'S MAIDEN NAME <i>SARAH ?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>095-16-9082</i>	
17. INFORMANT <i>Mrs. ADELE FEINGERSH (DAUGHTER)</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> DUE TO (b) <i>Coronary Artery Heart Disease</i> DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>Dec. 4 1967</i>	
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-7-67</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>ALEXINGTON NATIONAL CEM.</i>		23d. LOCATION (City or Town) <i>ALEXINGTON, VA.</i>	
24. FUNERAL DIRECTOR <i>Concord Funeral Home 4217 Grant St. N.W.</i>		ADDRESS	
25a. REC'D BY REGISTRAR DATE <i>DEC. 8 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17269

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
2 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 2 and 3 after death.

1 PLACE OF DEATH a COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) b STATE	
Montgomery County, Maryland		Md.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN lb	
Takoma Park		1 day	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e IS RESIDENCE ON A FARM?	
Washington Sanitarium and Hosp		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
655001/Ridg's Rd.			
3. NAME OF DECEASED (Type or print)		First <u>James</u>	Middle <u>Henry</u>
Kendall		Last <u>Kendall</u>	e DATE OF DEATH
5 SEX		7 MARRIED	8 DATE OF BIRTH
M		<input type="checkbox"/> NEVER MARRIED	9 AGE (In years last birthday) yrs
White		<input checked="" type="checkbox"/> WIDOWED	98
		<input type="checkbox"/> DIVORCED	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)
Mercantile business		mercantile	Chicago, Illinois
13 FATHER'S NAME		12 CITIZEN OF WHAT COUNTRY?	
George H. Kendall		U.S.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	17 INFORMANT
No		Md. St. A/c 1604-3379690	Mr. Ernest Kendall Mr. James C. Kendall
			Address 504 Dennis, Ave, S.S. 11811 Columbia Pike
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4341 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause just		DUE TO (b) DUE TO (c) Congestive heart failure 6 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS A TROPY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 12/19, 1967, that (I) (we) last saw the deceased alive on 12/19 1967, and that death occurred at 6 P.M. from causes and on the date stated above		22b. DATE SIGNED 12/20/67	
22a SIGNATURE <u>A. Tribadean</u>		MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) A. Tribadean		22d ADDRESS 10111 Colleville Road, Silver Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Dec. 21, 1967	23c NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery
24. FUNERAL DIRECTOR John Thomas Tribadean, Inc.		8434 ADDRESS Boronia Avenue Silver Spring, Md.	23d LOCATION (City or Town) (County) (State) Rockville, Maryland
		25a REC'D BY REGISTRAR DEC 27 1967	25d REGISTRAR'S SIGNATURE Thomas Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17269

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) D.C.	
3. NAME OF DECEASED (Type or print) Lee		First B.	Middle Kistler
4. DATE OF DEATH Month 12 Month 14 Year 1967		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/3/84?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Plate Printer		10b. KIND OF BUSINESS OR INDUSTRY US Gov't (Ret)	
11. BIRTHPLACE (County & State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lemon Kistler		14. MOTHER'S MAIDEN NAME Orcelia (Last Name Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No If yes give war or dates of service None		16. SOCIAL SECURITY NO 579-60-2207	
17. INFORMANT Mrs. B. K. Lloyd, Potomac, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRAIN TUMOR DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) ARTERIOSCLEROTIC VASCULAR DISEASE	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) New	(County) 6 (State) Dec
21. I certify that (I) (this hospital) attended the deceased from 12-13 19 67 to 12-14 19 67 , that (I) (we) last saw the deceased alive on 12-13 19 67 , and that death occurred at 9:20 A.M. from causes and on the date stated above		22. SIGNATURE Bernard A Fitzgerald	
22c. PHYSICIAN'S NAME (Type) BERNARD A Fitzgerald		22d. ADDRESS 217 Union Blvd E Silver Sp., Md.	22e. DATE SIGNED 12-14-67
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/18/67	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery
24. FUNERAL DIRECTOR Lee Funeral Home, 300 4th, NE, Wash, DC		23d. LOCATION (City or Town) Suitland, Pr. Geo, Md.	(County) Pr. Geo (State) Md.
		25a. REC'D BY REGISTRAR DEC 18 1967	25b. REGISTRAR'S SIGNATURE <i>James Judge</i>



100



1
2
17230

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11270

**FOR STATE
HEALTH DEPT.**

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 may be retained for your files.

1 PLACE OF DEATH a COUNTY Montgomery - MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b STATE Maryland b COUNTY Montgomery -	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda -		c LENGTH OF STAY IN lb d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8502 Rayburn Rd.	
d STREET ADDRESS 8502 Rayburn Rd.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First J	Middle Leo	Last Kolb
4 DATE OF DEATH Month December Day 26 Year 1967			
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 13, 1911
9 AGE (In years last birthday) 56 yrs	10b KIND OF BUSINESS OR INDUSTRY U.S. GOVT.	11 BIRTHPLACE (State or foreign country) D.C.	12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME JOSEPH LEO KOLB, JR.	14 MOTHER'S MAIDEN NAME Louise A. STANTON		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16 SOCIAL SECURITY NO II	17 INFORMANT (Wife) MARY AGNES KOLB - SAME AS #2	Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 976X Gun Shot Wound - 05 - Head -			INTERVAL BETWEEN ONSET AND DEATH Sudden
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a MEDICAL CERTIFICATION EXTERNA CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Shot self in head with 38 cal. Revolver -		
20c TIME OF INJURY Month Day, Year Hour 7:00 p.m. 12/26/1967	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home farm factory, street, office bldg. etc.) Home	20f (City or town) Bethesda (County) Montgomery (State) Md
21 I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John S. Bell</i>	MD	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 12/26/67
EXAMINER'S NAME (Type) <i>James E. DeVol - DC Vol Funeral Home - Wash D.C.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL CREMATION REMOVAL (Specify) BURIAL	23b DATE THEREOF 12-30-67	23c NAME OF CEMETERY OR CREMATORIUM Holy Road Cem.	23d LOCATION (City or Town) WASHINGTON (County) D.C. (State)
24 FUNERAL DIRECTOR <i>James E. DeVol - DC Vol Funeral Home - Wash D.C.</i>	ADDRESS	25a REC'D BY REGISTRAR JAN 2 1968	25b REGISTRAR'S SIGNATURE <i>new judge</i>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This cert cert should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Med Cal Examiner's Office along with form 2M3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17271

17271

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <i>Michigan</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Wayne</i>	
c. LENGTH OF STAY IN LB <i>D.O.A.</i>		c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <i>Detroit</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to., g ve street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>18029 Schonheer Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Dorothy</i>	Middle <i>Lampman</i>	4. DATE OF DEATH Month <i>December</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 9, 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	9. AGE (In years lost birthday) <i>74 yrs</i>
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Wyatt</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Vickery</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>yes</i>	17. INFORMANT <i>William A. Lampman</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		Acute Coronary Insufficiency Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden Reap</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (if not in same county) <i>Toronto</i>		22. DATE SIGNED <i>DEC. 8/1967</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Dec. 11, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Windsor Grove Cemetery</i>	23d. LOCAT ON (City or Town) (County) (State) <i>Ontario, Canada</i>
24. FUNERAL DIRECTOR <i>G. Glen Carter</i>	ADDRESS <i>8434 Georgia Avenue</i>	25a. REC'D BY REG STRAR <i>Charles J. Warner E. Pumphrey, Inc.</i>	25b. REG STRAR'S SIGNATURE <i>Charles J. Warner E. Pumphrey, Inc.</i>
Page 3		DATE DEC 11 1967	

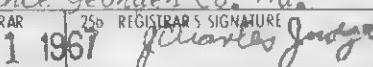


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb D.O.T.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital of Silver Spring		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland	
3. NAME OF DECEASED (Type or print) Mark		First Everett	Middle Last Lavery
4. DATE OF DEATH Month December		Day 6	Year 1967
5. SEX male	6. COLOR OR RACE cauc	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 7-28-66		9. AGE (In years lost birthday) 16 months	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) minor		10b. KIND OF BUSINESS OR INDUSTRY not employed	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John M. Lavery		14. MOTHER'S MAIDEN NAME Iris Mayberry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Mother		Address 500 Highgate Ter. Silver Spring, Md. IRIS LAVERY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 745X		(b) SCOLIOSIS + KYPHOSIS + DEFORMITY OF THORAX 16 mos	
		(c) BIRTH DEFECTS OF SPINE. ABS 16 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC URINARY TRACT INFECTION DUE TO CONGENITAL G-U DEFECTS POSTOPERATIVE HYDRONEPHROSIS + MYELOMENINGOCELE		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/31 , 19 66 , to 12/6 , 19 67 , that (I) (we) last saw the deceased alive on October 8, 1967 , and that death occurred at 1251 M , from causes and on the date stated above.		22b. DATE SIGNED 12/6/67	
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) George Cohen		22d. ADDRESS 9919 Georgia Ave., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Dec. 7, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR Thomas J. Chalk, Jr.		25a. ADDRESS 8434 Georgia Avenue	
25b. ADDRESS Warren E. Lumpkin, Inc. Silver Spring, Md.		25c. REC'D BY REGISTRAR DEC 11 1967	
		25d. REGISTRAR'S SIGNATURE 	



TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

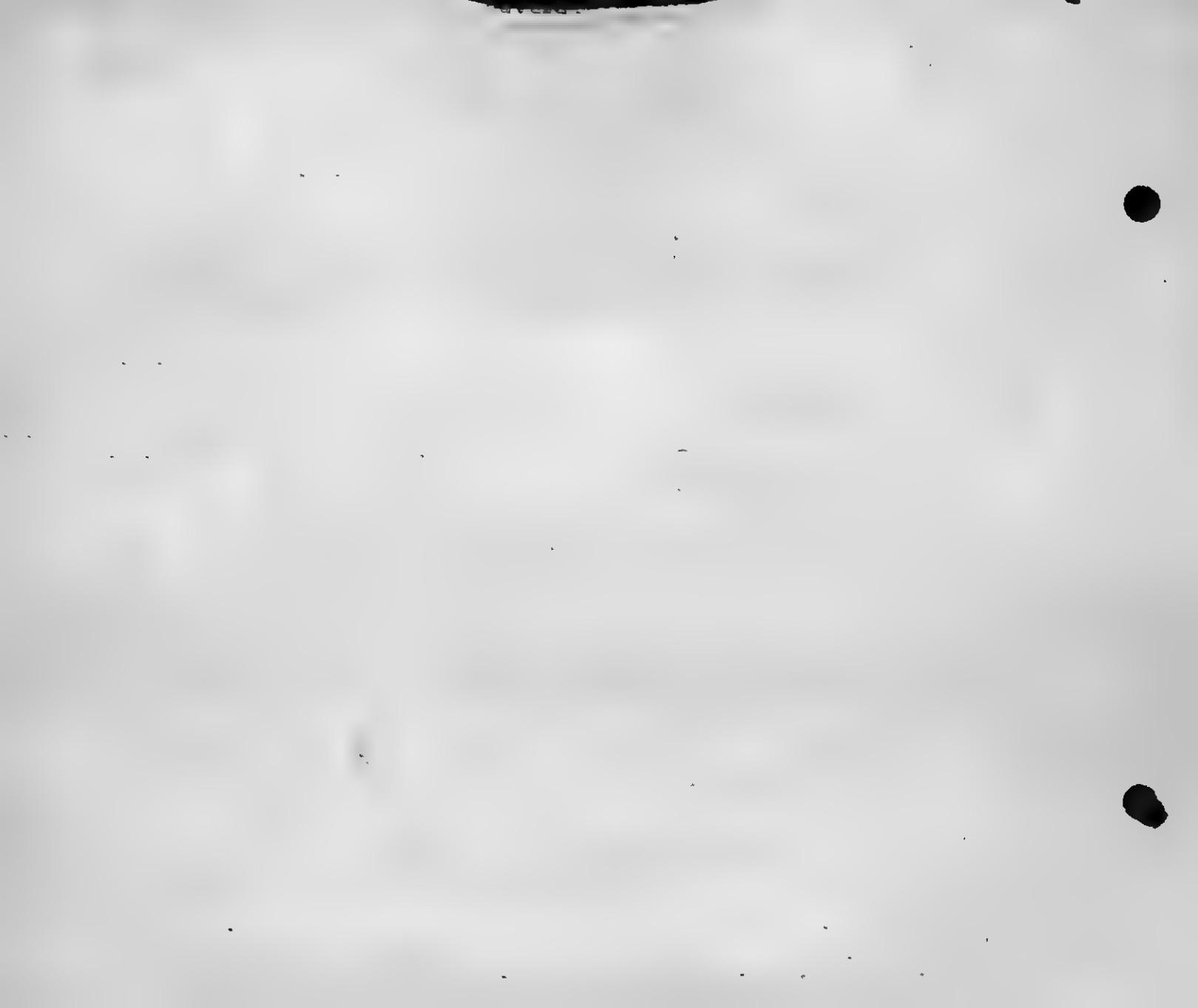
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17273

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Res dence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN TB <i>34 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Carroll Hall Sanitarium</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arlington, D. C.</i>	
3. NAME OF DECEASED (Type or print) <i>HATTIE</i>		f. STREET ADDRESS <i>417 Vanover Street, S.E.</i>	
4. SEX <i>Female</i>	5. COLOR OR RACE <i>White</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>M. 24 May 3, 1976</i>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	9. KIND OF BUSINESS OR INDUSTRY <i>No business</i>	10. BIRTHPLACE (County & State, or foreign country) <i>Louisiana, U.S.A.</i>	11. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
12. FATHER'S NAME <i>Clarence Gram Head</i>	13. MOTHER'S MAIDEN NAME <i>Margaret E. Rollins</i>	14. ADDRESS <i>417 Vanover Street, S.E., Arlington, Virginia</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) <i>No</i>
16. SOCIAL SECURITY NO. <i>570-62-0514</i>		17. INFORMANT <i>Daughter</i>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Failure</i> DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. <i>Cardiovascular Renal Disease</i> (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>None.</i>	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from... saw the deceased alive on... and that death occurred at <i>615 M St.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>Dec. 22, 1967</i>	
22a. SIGNATURE <i>Lyndwood Heights, M.D. F.A.C.P.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME <i>John C. Den Carter</i>		22d. ADDRESS <i>6190 Pimley Branch Rd., NW Wash. DC</i>	
23a. BURIAL OR CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 27, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Union Cemetery</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Constance L. Den Carter</i>		ADDRESS <i>6190 Pimley Branch Rd., NW Wash. DC</i>	25a. REC'D BY REGISTRAR DATE <i>Dec 28 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Elaine Judge</i>

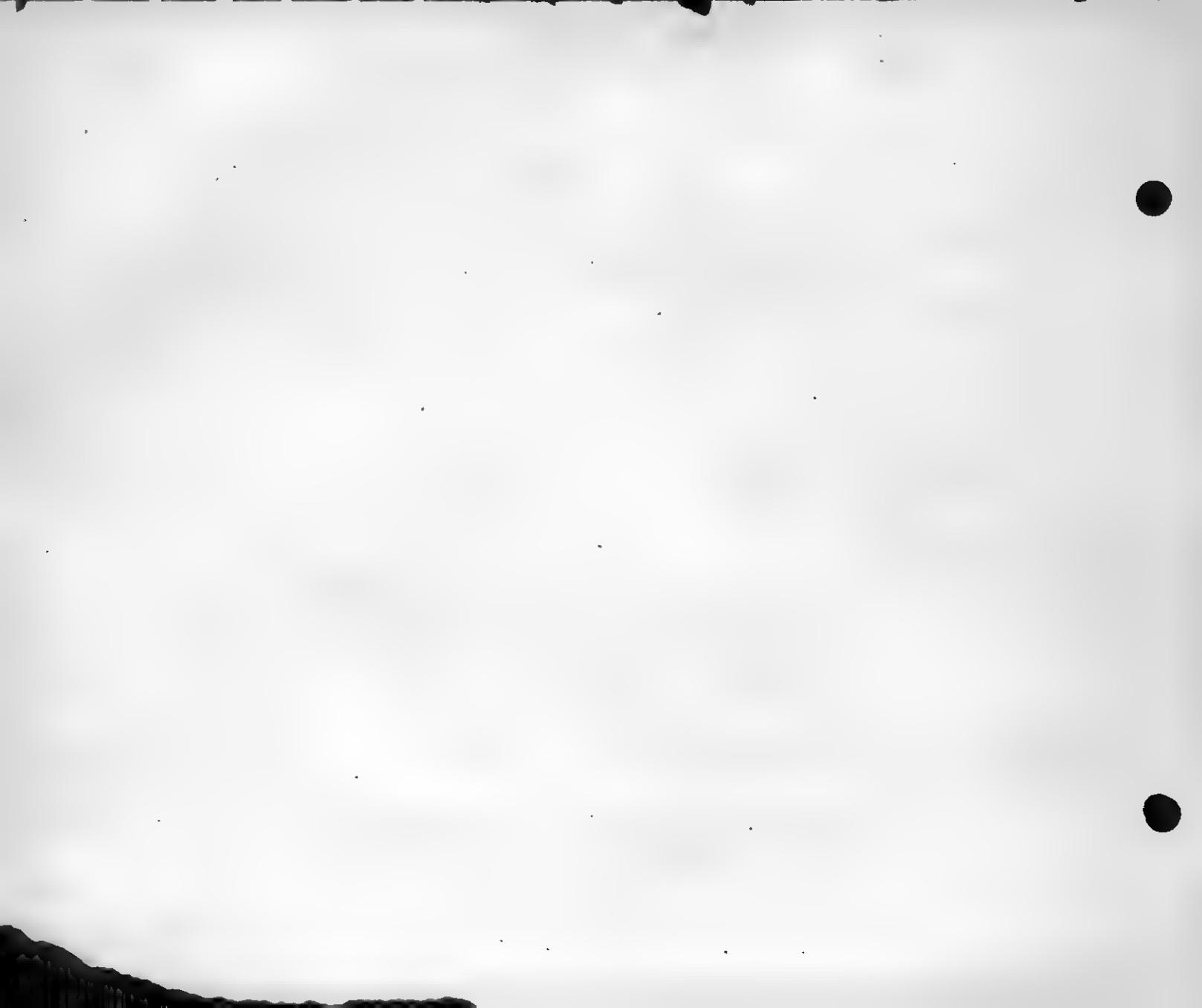


MARYLAND STATE DEPARTMENT OF HEALTH

The death certificate be executed within 24 hours after death.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
Montgomery MARYLAND			a. STATE Washington b. COUNTY D.C.											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.											
c. LENGTH OF STAY IN 1b 3 Years			d. STREET ADDRESS 1660 Lainer Pl., N.W.											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cedar Haven Rest Home			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED First Florence Middle Martin Last Leary			4. DATE OF DEATH December 7 1967											
(Type or print)														
5. SEX Female Cauc 6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Mar 31 1894			9. AGE (in years last birthday) 73 7 months			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse 11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY USA		
10b. KIND OF BUSINESS OR INDUSTRY														
13. FATHER'S NAME E John H. Martin			14. MOTHER'S MAIDEN NAME Effie Burritt											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT John H. Martin, 1660 Lainer Pl., Wash.			Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - Rt lower lobe			INTERVAL BETWEEN ONSET AND DEATH 3 days								
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			DUE TO (b) PARKINSON'S DISEASE - Advanced			6 mos								
			DUE TO (c) GENERALIZED ALZHEIMER'S DISEASE			10 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> p.m. 19			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from 1962, 19, to 12-7, 1967, that (I/we) last saw the deceased alive on Dec 6th 1967, and that death occurred at 5:30 AM, from the causes and on the date stated above.														
22a. SIGNATURE Richard B. Perry MD			22b. DATE SIGNED 12-7-67											
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/9/67			23c. NAME OF CEMETERY OR CREMATORIUM Riverside Cemetery			23d. LOCATION (City, town or county) Asheville, North Carolina (State)					
24. FUNERAL DIRECTOR Lee Funeral Home 300 4th St N.E.			ADDRESS			25a. REC'D BY REGISTRAR 25b. REC'D TRANS SIGNATURE								
						11 1967 Charles Judge								

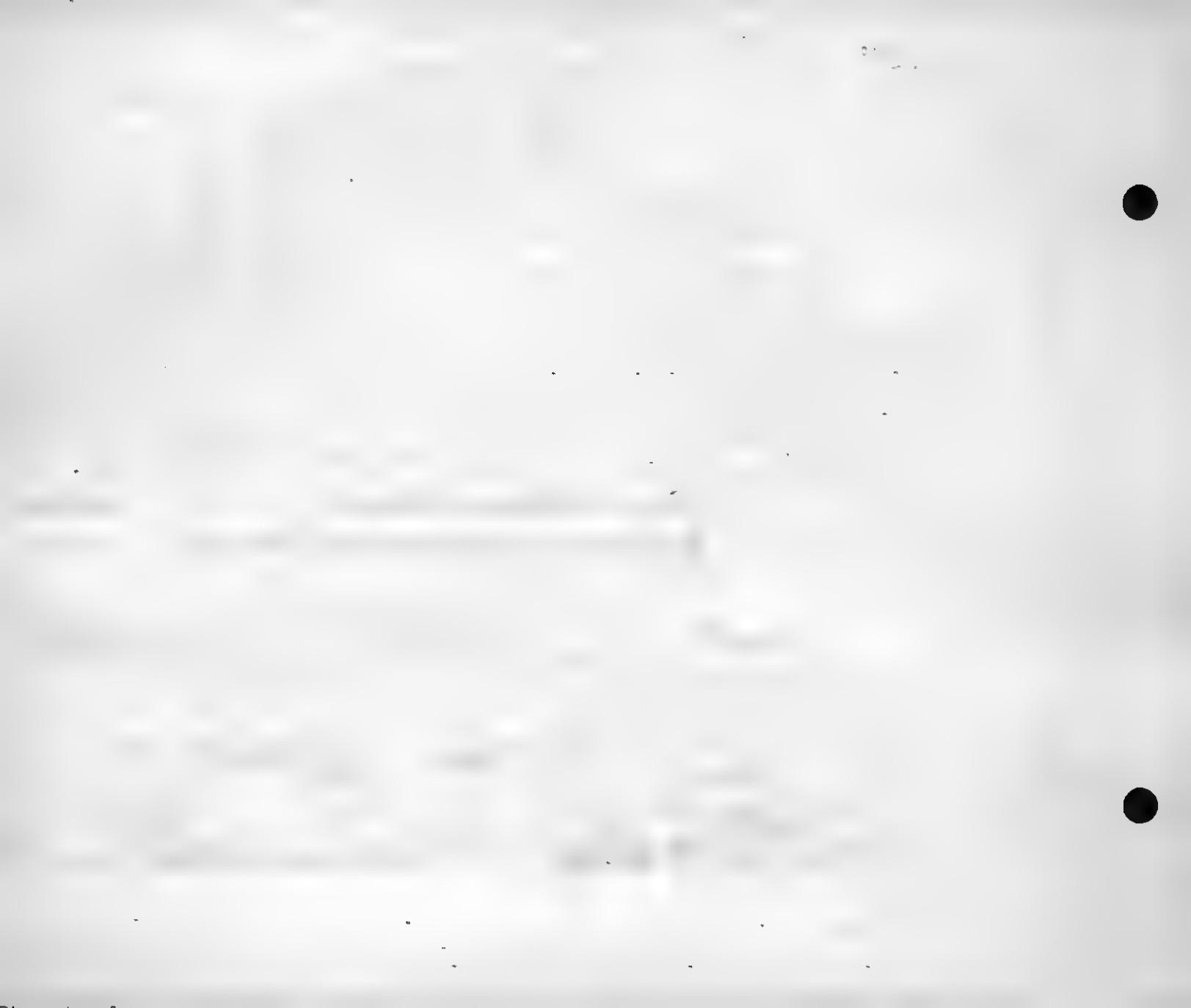


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>		c. LENGTH OF STAY IN TB <u>4 days</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>						d. STREET ADDRESS <u>1204 Oakview Drive</u>					
3. NAME OF DECEASED (Type or print) <u>Robert Charles Leary</u>			First	Middle	Last	4. DATE OF DEATH <u>Dec 7 1967</u>	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/04</u>	9. AGE (In years lost birthday) <u>63 yrs.</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ass't. Administrator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>			11. BIRTHPLACE (County & State or foreign country) <u>Montana</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John C. Leary</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Kelly</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W.II</u>			16. SOCIAL SECURITY NO <u>577-60-0117</u>			17. INFORMANT <u>Mrs. Margaret Leary</u>			Address <u>1204 Oakview Drive Silver Spring, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>					
443X			DUE TO								
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.			(b) <u>Hypertensive cardiovascular disease</u>			DUE TO			10 years		
(c)											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)											
None											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>p.m.</u> <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Jam</u>		(County) <u>1963</u>		(State) <u>10 Dec 7 1967</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jam</u> , 1963 to <u>Dec 7</u> , 1967, that (I) (we) last saw the deceased alive on <u>Dec 7</u> , 1967, and that death occurred at <u>2:45 PM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Blaine H. E. P.</u>											
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. E. P.</u>		M.D. <input type="checkbox"/> ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/8/67</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) <u>Silver Spring, Md.</u>		(County) <u>1967</u> (State)			
24. CEMETERY DIRECTOR <u>Charles H. Thomas</u>		ADDRESS <u>18 Thomas 8434 Georgia Ave.</u>		25a. REC'D BY REGISTRAR <u>DEC 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
Warren E. Pumphrey, Inc.		Silver Spring, Md.		DATE							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1- and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

-1-276

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 16 DOA		a. STATE MARYLAND b. COUNTY MONTGOMERY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		e. STREET ADDRESS 1100 Bradley Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle Bonifant	Last LEIBIG	4. DATE OF DEATH Month DECEMBER 28	Day Year 19 67
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/14/85	9. AGE (In years last birthday) 82 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State or foreign country) Columbia, Maryland	
13. FATHER'S NAME George Bonifant		14. MOTHER'S MAIDEN NAME Helen Green		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 123-45-6789		17. INFORMANT Charmi Leibig Silver Spring, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute pulmonary edema				INTERVAL BETWEEN ONSET AND DEATH 1 hr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Longstanding heart failure		(b) Arteriosclerosis coronary disease		48 hrs	
		(c) Arteriosclerosis coronary disease		15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Dec 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakville	(County) Montgomery (State) MD
21. I certify that (I) (this hospital) attended the deceased from Jan 1952 to Dec 1967 , that (I) (we) last saw the deceased alive on Dec 17 1967 , and that death occurred at 9:10 AM , from causes and on the date stated above.					
22a. SIGNATURE A. DEMENT BONIFANT, M.D.		22b. DATE SIGNED 12-29-67			
22c. PHYSICIAN'S NAME (Type) A. DEMENT BONIFANT, M.D.		22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 30, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Rocklawn Cemetery		23d. LOCATION (City or Town) Oakville, Maryland (County) Montgomery (State) MD
24. FUNERAL DIRECTOR James J. Murphy		25a. ADDRESS 1100 Bradley Rd.	25b. REGD. BY REGISTRAR JAN 8 1968		25c. REGISTRAR'S SIGNATURE Charles Judge



M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

17277

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Wheaton

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

University Nursing Home

3. NAME OF DECEASED
(Type or print)

First
Susie

Middle
Mary

Last
Leigh

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED **NEVER MARRIED**

WIDOWED

DIVORCED

8. DATE OF BIRTH

7/7/1881

9. AGE (In years last birthday)

86 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Charlotte Co., Va.

12. CITIZEN OF WHAT COUNTRY?

N.V.

13. FATHER'S NAME

Jamerson Fulton Mercer White

14. MOTHER'S MAIDEN NAME

Mary Frances Henderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address 2700 Newlands St

Washington, DC

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

4500

DOUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Generalized infected decubiti

INTERVAL BETWEEN
ONSET AND DEATH

2 days

(c)

Generalized atresione

3 mos.

4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 6-20, 1967 to 12-6, 1967, that (I) (we) last saw the deceased alive on 11-7, 1967, and that death occurred at 12th AM, from the causes and on the date stated above.

22e. SIGNATURE

Herbert Tanenbaum, M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED
12-6-67

22c. PHYSICIAN'S NAME (Type)

Herbert L. Tanenbaum 4400 Coan Ave. NW Wash. D.C.

22d. ADDRESS

23e. BURIAL, CREMATION, REMOVAL (Specify)
Burial 12/8/67

23e. NAME OF CEMETERY OR CREMATORIAL
Cedar Hill Cemetery

23d. LOCATION (City, town or county)
Prince Georges Co. Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE

The S.H. Hines Co. Washington, D. C.

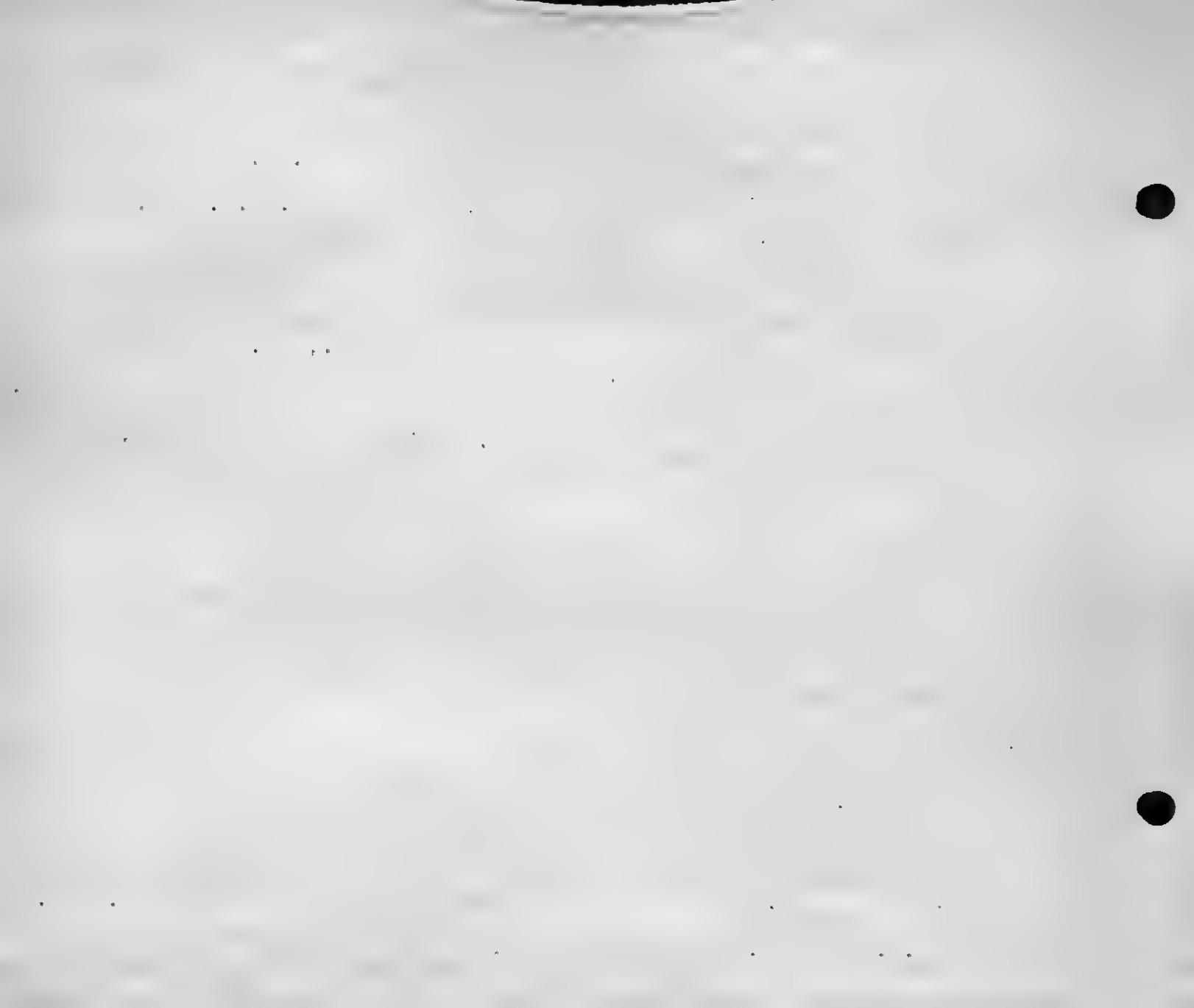
ADDRESS

25e. REC'D BY REGISTRAR

DEC 7 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film No. 17278

CERTIFICATE OF DEATH

17278

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		d. STREET ADDRESS 11108 Post House Ct.		
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First EMILIE	Middle L.	Last LEPPERT	
4. DATE OF DEATH Nov Dec. 1, 1967	Month Year	Doy Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	
8. AGE (In years at last birthday) 78 yrs	9. DATE OF BIRTH April 9, 1889	10. UNDER 1 YEAR Months 0	11. UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anton Kees		14. MOTHER'S MAIDEN NAME Louise Steckenner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-58-6515	17. INFORMANT Mrs Charles E. Rogers	
		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (Generalized) DUE TO (c) Decubitus		
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour c.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/25/67 to 12/1/67 , 1967, that (I) (we) last saw the deceased alive on 11/27/67 and that death occurred at M. from causes and on the date stated above.				22b. DATE SIGNED
22a. SIGNATURE T. Joyce		MD ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) T. Joyce		22d. ADDRESS 4977 Battery Lane, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/4/67	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.		ADDRESS	25a. REC'D BY REGISTRAR DEC 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE D.C.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. LENGTH OF STAY IN 1b 6 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNIVERSITY NURSING HOME		e. STREET ADDRESS 6445 LUZON AVE. N.W.		
f. ZIP CODE 20040		g. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EVA		First AURELIA	Middle LESTER	
4. DATE OF DEATH Month Dec. 4, 1967		5. MONTH Dec.	6. DAY 4	
7. SEX F		8. COLOR OR RACE Caucasian	9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOV'T CLERK		10b. KIND OF BUSINESS OR INDUSTRY GOV'T	11. BIRTHPLACE (County & State, or foreign country) COLUMBIA S.C.	
13. FATHER'S NAME William F. Lester		14. MOTHER'S MAIDEN NAME Minnie, A. North		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-44-5374	17. INFORMANT self	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 3321 DUE TO (b) Cerebrovascular insufficiency DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 1 hour		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his/his hospital) attended the deceased from July 12/2 1969 , to Dec. 4, 1969 , that (I) (we) last saw the deceased alive on 12/2 1969 , and the death occurred at 8:15 P.M. , from causes and on the date stated above.				
22a. SIGNATURE James R. Coleman MD		M.D. <input type="checkbox"/> ATTENDING PHYS. James R. COLEMAN	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. JAMES R. COLEMAN	22b. DATE SIGNED 12/4/67
22c. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN		22d. ADDRESS 9141 COLUMBIA BLVD SILVER SPRING, MD.		
23a. BURIAL CREMATION, burial REMOVAL (Specify)		23b. DATE THEREOF 12/7/67	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR John H. Morris Jr. 2901 14th NW DC		ADDRESS	25a. RECD BY REGISTRAR DEC 7 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17240

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery MARYLAND		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		b. COUNTY	
c. LENGTH OF STAY IN Tb 15 + years		Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
		d. STREET ADDRESS 13130 Holdridge Rd.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First RUTH	Middle LEVENSON
4. DATE OF DEATH		Month DEC.	Day 10
		Year 1967	
S SEX <i>F</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 27, 1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SECRETARY</i>		9. AGE (in years lost birthday) 44 yrs	
10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) NEW YORK	
13. FATHER'S NAME MAX CULLICOVER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO —	
17. INFORMANT HUSBAND SYDNEY LEVISON		Address SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		9 months	
DUE TO (c) <i>Infiltrating Duct Cell Carcinoma of Breast</i>		16 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <i>None</i>		19. WAS A POSTMORTEM EXAMINATION PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sydney</i> , 1967, to Dec. 10, 1967, that (I) (we) last saw the deceased alive on <i>Dec. 10, 1967</i> , and that death occurred at <i>12:30 P.M.</i> from causes and on the date stated above.		22. DATE SIGNED Dec. 10, 1967	
22a. SIGNATURE <i>Gene U. Cohen, M.D.</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) GENE U. COHEN, M.D.		22d. ADDRESS 106 SPRING ST. SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 11, 1967	23c. NAME OF CEMETERY OR CREMATORIAL B'Nai Israel Cemetery
23d. LOCATION (City or Town) Oxon Hill,		(County) (State) Maryland.	
24. FUNERAL DIRECTOR Donald M. Stein Hebrew ADDRESS 232 Carroll St., N.W.-Wash., D.C.		25a. REC'D BY REGISTRAR DEC 18 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
new Memorial Funeral Home			



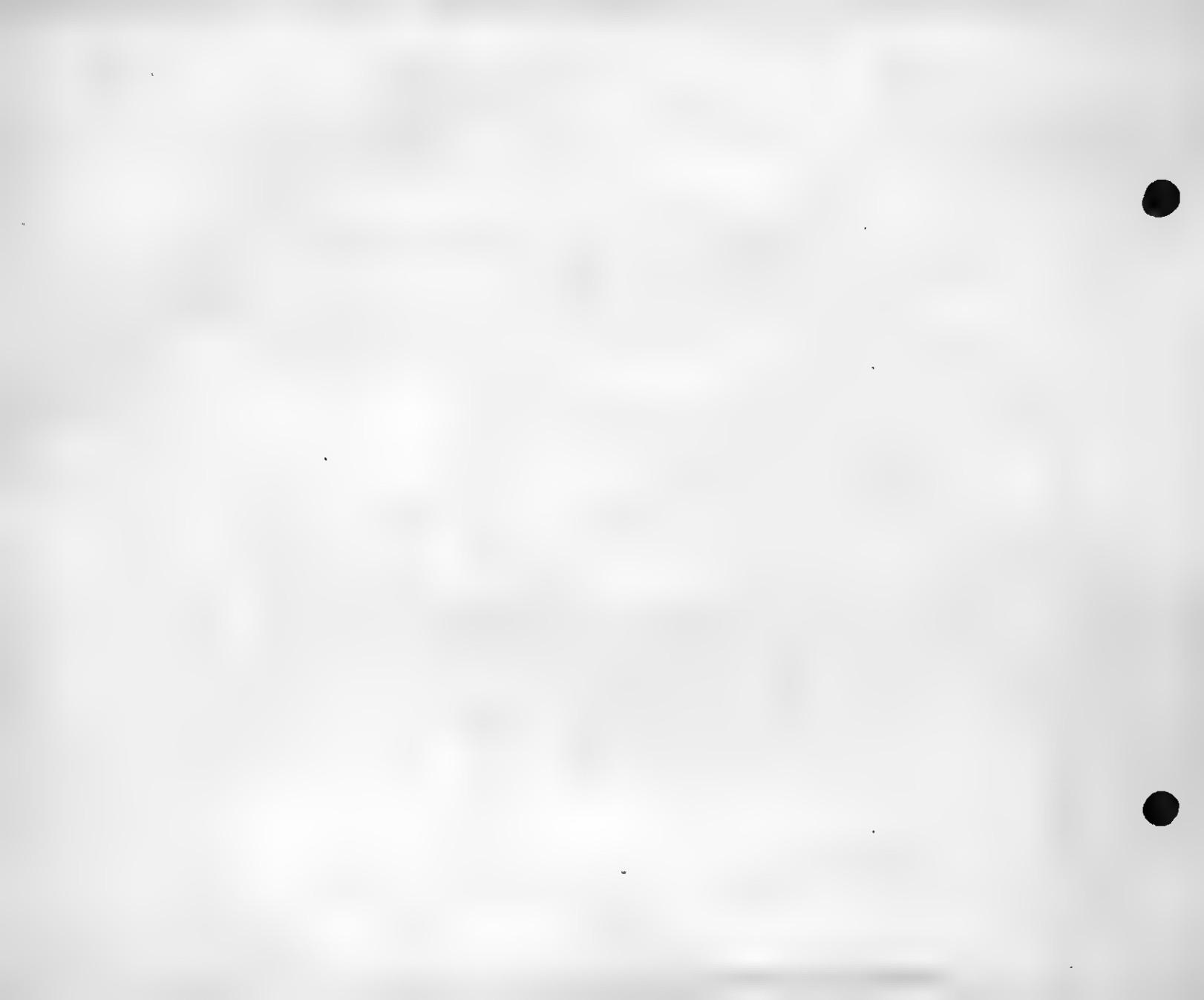
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>14 days</i>				
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington Gardens Sanitorium</i>		f. STREET ADDRESS <i>8606 Garland Ave</i>				
3. NAME OF DECEASED (Type or print)	First <i>FLORENCE</i>	Middle <i>C.</i>	Last <i>Lewis</i>			
4. DATE OF DEATH Month <i>12</i>	Month <i>1</i>	Day <i>19</i>	Year <i>67</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>8-28 1886</i>	9. AGE (In years last birthday) <i>81 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Penna.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Henry Bowman</i>	14. MOTHER'S MAIDEN NAME <i>Ida Morgan</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <i>172-01-033-88</i>				
16. SOCIAL SECURITY NO <i>172-01-033-88</i>	17. INFORMANT <i>Mr. David P. Reigel, 8606 Garland Ave. T.P.M.</i>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of Stomach</i>		INTERVAL BETWEEN ONSET AND DEATH				
131 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anticoagulant Vascular Disease</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Oct 1967</i>	20f. (City or town) <i>New York</i>	(County) <i>New York</i>	(State) <i>New York</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1967</i> , to <i>Dec 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 1 1967</i> , and that death occurred at <i>350 M</i> , from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. SIGNATURE <i>Bernard A. Fitzgerald</i>		22b. DATE SIGNED <i>12-1-67</i>				
22c. PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>		22d. ADDRESS <i>217 UNIV. BLVD. E., Silver Spring, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 7 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>New Darby Cemetery</i>	23d. LOCATION (City or Town) <i>New Darby</i>	(County) <i>New York</i>	(State) <i>New York</i>
24. FUNERAL DIRECTOR <i>Arthur Nettie, 252 Carroll St. N.W.</i>		ADDRESS <i>10</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE DEC 5 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
Montgomery MARYLAND		Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c LENGTH OF STAY IN lb 30 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annandale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS 7709 Royston Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)		First Leland	Middle Price
4 DATE OF DEATH		Month December	Doy 28 Year 1967
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH 25 March 1924
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 AGE (In years lost birthday) 43 yrs
10b KIND OF BUSINESS OR INDUSTRY Engineer		11. BIRTHPLACE (County & State, or foreign country) California	
12 CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Edgar H. Lewis		14. MOTHER'S MAIDEN NAME Bertha Deer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 1941-45	
17. INFORMANT Yes		The Medical Records Address Not Available The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 10 hours	
1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		24 hours	
(b) Hepatorenal Failure		3 years	
(c) Metastatic Teratocarcinoma			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDER. YNG <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
		20f (City or town)	(County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 28 November 1967, to 28 Dec. 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 28 December 1967, and that death occurred at 4:58 P.M., from causes and on the date stated above		PM	
22a SIGNATURE <i>Charles Haskell</i>		22b. DATE SIGNED 1967 29 December	
22c. PHYSICIAN'S NAME (Type) Charles M. Haskell, M. D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/16/67	
		23c. NAME OF CEMETERY OR CREMATORIAL Culpepper National	
23d. LOCATION (City or Town) Culpepper, Virginia		(County) (State)	
24. FUNERAL DIRECTOR <i>Robert Deral</i> Covington-Martin		ADDRESS Falls Church, Va.	
		25a. REC'D BY REGISTRAR DAIAN 3 1968	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and attach page 3 to the back of this certificate. This will allow you to attach the burial-transit permit to the death certificate.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) b. STATE <i>MD.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakoma Park</i>		c. LENGTH OF STAY IN b. <i>1 week</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>Washington Sanitarium + Hospital, 1707 Priscilla dr.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium + Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JESSE</i>		First <i>EDGAR</i>	Middle <i>LITTLE</i>
4. DATE OF DEATH <i>12 16 67</i>		Month <i>Dec</i>	Day Year <i>16 1967</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USIA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Claim Adjuster</i>		9. DATE OF BIRTH <i>12-16-88</i>	
10a. KIND OF BUSINESS OR INDUSTRY <i></i>		10b. AGE (In years last birthday) <i>79 yrs</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>ILL.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Little</i>		14. MOTHER'S MAIDEN NAME <i>Jennie Walker</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>Pt. Chart.</i>	
17. INFORMANT <i></i>		Address <i></i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage L. hem. gl. - gen.</i>		INTERVAL BETWEEN DEATH AND DEATH <i>1 day</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerosis & probably gouty</i>			
DUE TO (b) <i>by fracture?</i>			
DUE TO (c) <i>ju</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) (State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>12-4</i> , 19 <i>67</i> , to <i>12-16</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>8:55 P.M.</i> from causes and on the date stated above		22a. SIGNATURE <i>J. H. Walker</i>	
22b. DATE SIGNED <i>8-31-67</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Chas H. Walker</i>		22d. ADDRESS <i>831 Union St. Bldg. E, #5</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 19-1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Union Cemetery</i>
23d. LOCATED (City or Town) <i>Baltimore</i>		23e. COUNTY (County) <i>Maryland</i>	
24. FUNERAL DIRECTOR <i>DeWitt Donaldson</i>		ADDRESS <i>Laurel, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 27 1967</i>
25b. REGISTRAR'S SIGNATURE <i>DeWitt Donaldson</i>			



1

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17284

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND MONTGOM.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 4 YEARS		c. LENGTH OF STAY IN lb d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2122 ARCOLA AVENUE		d. STREET ADDRESS 2122 ARCOLA AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (First, Middle, Last) JOHN F. LONG		4. DATE OF DEATH Month DEC. Month 5 Year 1967	Doy Year
S. SEX M	6. COLOR OR RACE CAUC	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-1949 18 yrs
9. O.S.-AL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WASH., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN B. LONG		14. MOTHER'S MAIDEN NAME EVELYN L. Riggs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-54-2107	17. INFORMANT FATHER Address 2122 Arcola Avenue Silver Spring, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. 1250		INTERVAL BETWEEN ONSET AND DEATH CARDIORESPIRATORY FAILURE DUE TO SUFFOCATION, ACCIDENTAL.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part III of Item 18.) Decedent used plastic bag about head while inhaling medicine & served in judgment.	
20c. TIME OF INJURY Month, Day, Year 12-5 1967		20d. INJURY OCCURRED Wh. at work <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) HOME City or town Silver Spring, Montgom. Md. State (Md.)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (if not in town or county)	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D., Wheaton		22. DATE SIGNED DEC. 6, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 8, 1967	23c. NAME OF CEMETERY OR CREMATORIAL FACILITY Rock Creek Cemetery
24. CEMETERY DIRECTOR C. Glen Carter		25a. ADDRESS 8434 Georgia Avenue	25b. LOCATION (City or Town) Washington, D. C. (County) (State)
24. CEMETERY DIRECTOR Warren E. Pumphrey, Inc.		25b. REC'D BY REGISTRAR Charles J. Jurgens	25b. REGISTRAR'S SIGNATURE Charles Jurgens
VR A15ME (5) 6M 1/67		DATE DEC 11 1967	

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• $\frac{1}{2} \times 10^6$ cm^{-2} sec^{-1}

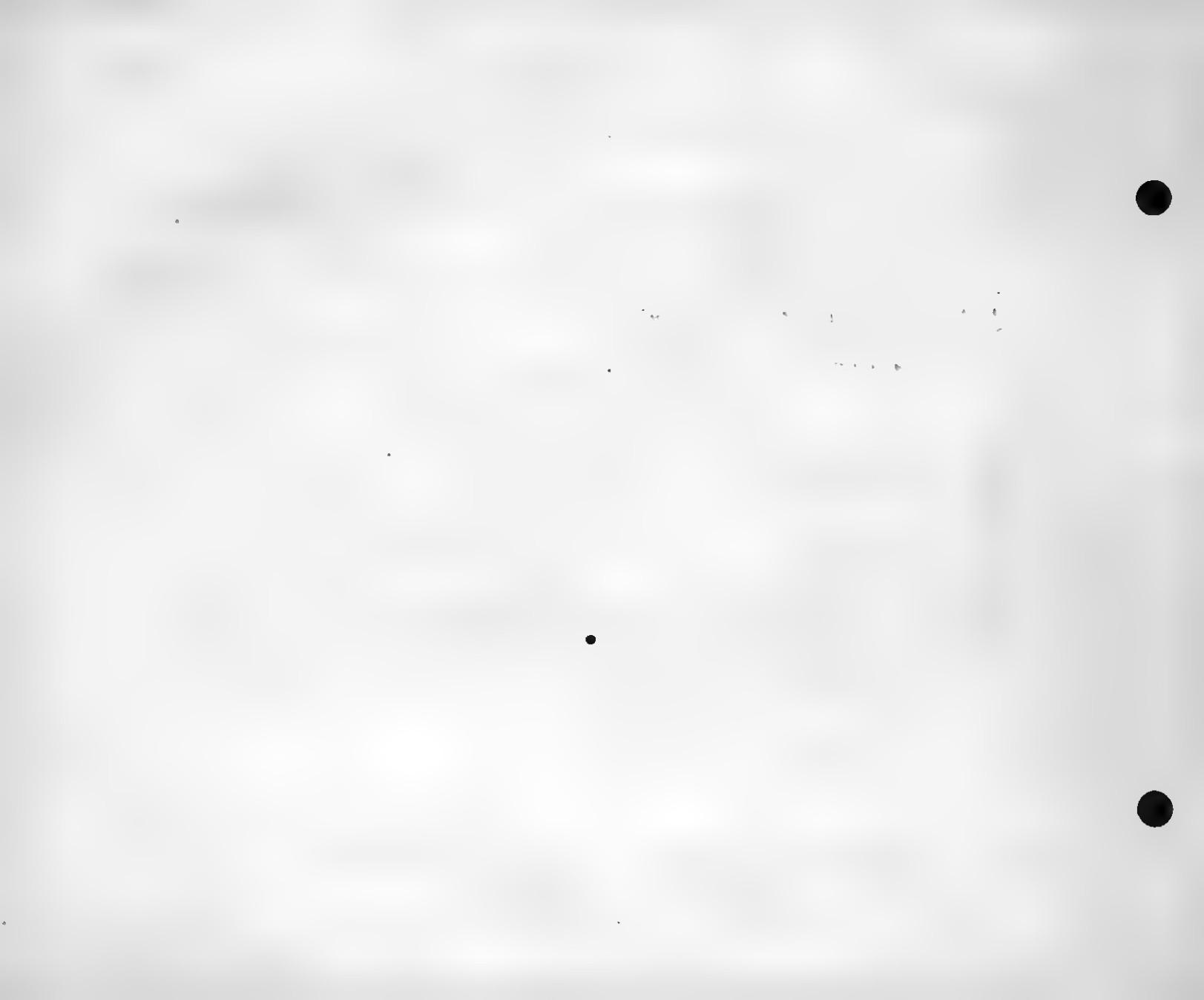
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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Cleared by medical Examiner Dr. Roff

CERTIFICATE OF DEATH					
PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		
a. COUNTY	<i>Montgomery County Maryland</i>		a. STATE	<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN TB	b. COUNTY	
<i>Silver Spring</i>			1 day		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Holy Cross Hospital</i>				<i>Baltimore</i>	
3. NAME OF DECEASED (First Middle Last)			4. DATE OF DEATH	e. IS RESIDENCE ON A FARM?	
<i>Grace C. Louthan</i>			December 31 1967	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX	6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min
<i>Female</i>	<i>White</i>	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	<i>6/20/92</i>	<i>75 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
<i>Retired clerk & typist U.S. News & World Report</i>				<i>North Carolina</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<i>John Baxter Clegg</i>		<i>Sarah Elizabeth Atwater</i>		<i>U.S.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
		<i>579-28-6532</i>		<i>Robert B. Louthan same as #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (c), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic breast carcinoma</i>					
11. DUE TO (b) <i>in multiple viscera</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) stating the underlying cause lost.					
12. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral arteriosclerosis</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Sept 17, 1958, to Dec 31, 1967, that (1) (we) last saw the deceased alive on Dec 31, 1967, and that death occurred at 8:45 PM, from causes and on the date stated above.		22. DATE SIGNED <i>Jan 1968</i>			
22a. SIGNATURE <i>Harry N. Carlton</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. ADDRESS <i>HARRY N. CARLTON, MD 8811 Columbia Rd. S.S. Md.</i>
22c. PHYSICIAN'S NAME (Type)					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF <i>1/3/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Prince Georges County, Md.</i>	
24. FUNERAL DIRECTOR <i>S.H. Hines Co. Wash. D.C.</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>DATRI 3 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MVR 3 Page 3 which may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17286

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURA, and give nearest town) <i>Rural Germantown</i>		2. USUAL RESIDENCE (Where deceased lived, if institutional, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>Rural Germantown</i>		c. CITY OR TOWN (if outside corporate limits, write RURA, and give nearest town) <i>Rural Germantown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Rt #1 King Valley Rd.</i>		d. STREET ADDRESS <i>Rt #1 King Valley Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Herbert Julian Lowe</i>	First <i>H</i>	Middle <i>J</i>	Last <i>Lowe Jr.</i>
4. DATE OF DEATH Month <i>Dec</i> Day <i>12</i> Year <i>1967</i>	Month	Day	Year
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 31 1967</i>
9. AGE (In years at birth)	IF UNDER 1 YEAR Months <i>3</i> Days <i>13</i> Hours <i>0</i> Min <i>0</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	Address		
13. FATHER'S NAME <i>Herbert Julian Lowe</i>	14. MOTHER'S MARRIED NAME <i>Martha Barnhouse</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronch. Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>27 days</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) <i>Laytonsville</i> (County) <i>Montgomery</i> (State) <i>Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>12/12/67</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-13-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Laytonsville</i>	23d. LOCATION (City or Town) <i>Laytonsville</i> (County) <i>Montgomery</i> (State) <i>Md</i>
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>	ADDRESS <i>Laytonsville, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 18 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) d. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>No longer</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>6013 Wilmet Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>HELEN F LYNCH</u>		4. DATE OF DEATH <u>DEC 31 1967</u>	b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/>
9. AGE (In years last birthday) <u>61 1/2 / 60</u>		10. DATE OF BIRTH <u>6/12/00</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Ross Walter</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Gochel</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Margot Gray Birmingham Ala.</u>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____
INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am pm <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bladensburg Md</u>
20f. (City or town) <u>Bladensburg</u> (County) <u>Maryland</u> (State) <u>Md</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 29 1967</u> to <u>- date</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 30 1967</u> , and that death occurred at <u>6:57</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>John G Ball</u>		22b. DATE SIGNED <u>31 Dec 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN G BALL</u>		22d. ADDRESS <u>MONTGOMERY COUNTY MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1-6-1968</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Holmes Cemetery</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co. 517-11585 DC</u>		25a. ADDRESS <u>Wash DC</u>	25b. REC'D BY REGISTRAR <u>JAN 9 1968</u>
		25c. REC'D BY REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	



2-1
Items 18-21 Film 396 MARYLAND STATE DEPARTMENT OF HEALTH
1-15-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN lb DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA-Montgomery General Hospital						d. STREET ADDRESS 905 Woodington Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) (Alfonso) Alphonse		First	Middle	Lost	4 DATE OF DEATH	Month	Day	Year			
S SEX	6 COLOR OR RACE	7 MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH	9 AGE (in years last birthday)	10 UNDER 1 YEAR Months	11 UNDER 24 HRS Days	Hours			
Male	Negro			4-6-1913	54 yrs						
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) Cement layer				10b. KIND OF BUSINESS OR INDUSTRY Construction			11. BIRTHPLACE (State or foreign country) Richmond, Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH MACK						14. MOTHER'S MAIDEN NAME VERA JOHNSON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service				16. SOCIAL SECURITY NO		17. INFORMANT Medical Records		Address HOSPITAL			
223-07-6620											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute right coronary occlusion with infarction;</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic heart disease</u> stating the underlying cause (c) <u>Arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) NO INJURY							
20c. TIME OF INJURY Month, Day Year Hour				20d. INJURY OCCURRED At work <input checked="" type="checkbox"/> Not at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Columbia / exist / Columbia City / MD / Howard County / MD /		20f. (City or town) Howard County / MD /		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Peap</u> M.D. EXAMINER'S NAME (Type) <u>Belden R. Peap, M.D.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ADDRESS <u>1701 Laurens</u> DATE <u>DEC. 19, 1967</u>											
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL				23b. DATE THEREOF 12-23-67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Morton + Dyer F.H. 1701 Laurens</u>		23d. LOCATION (City or Town) (County) (State) Balto. Md.			
24. FUNERAL DIRECTOR								25a. REC'D BY REG STRR DATE <u>DEC 21 1967</u>			
VR A15ME (5) 6M 1/67								25b. REGISTRAR'S SIGNATURE DATE <u>DEC 21 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton, Md.</i>		c. LENGTH OF STAY IN lb <i>6 wks</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>5634-Kansas Ave N.W.</i>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>University Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>		f. STREET ADDRESS <i>901 Arcola Ave - Wheaton</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ESSIE</i>		First	Middle	Last	4. DATE OF DEATH <i>HOPE JACKSON</i>	Month <i>12</i>	Day <i>9</i>	Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>3-6-1882</i>	9. AGE (In years last birthday) <i>85 yrs</i>	10. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Gaston, N.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Robert Gublick</i>		14. MOTHER'S MAIDEN NAME <i>Mary Lineberger</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>None No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Mary J. Byrd - 5634 Kansas Ave</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Carcinoma of Pancreas						INTERVAL BETWEEN ONSET AND DEATH <i>8 weeks</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)			
21. I certify that (I) (this hospital) attended the deceased from <i>11-10, 1967</i> to <i>12-9, 1967</i> that (I) (we) last saw the deceased alive on <i>12-8-67</i> and that death occurred at <i>6A.M.</i> from causes and on the date stated above.		22a. SIGNATURE <i>Myron L. Leibow</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS							
23a. BURIAL/CREMATON, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE THEREOF <i>12-16-67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>LINCOLN MEMORIAL CEMETERY</i>		23d. LOCATION (City or Town) <i>SUITLAND, MARYLAND</i>	(County) (State)			
24. FUNERAL DIRECTOR JOHN T. RHINES CO. ADDRESS <i>15 12TH STREET, N. E. WASH. D. C.</i>		25a. REC'D BY REGISTRAR <i>DEC 18 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17290

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove or torn papers pages 1, 2 and 4, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring (Takoma Park)</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross</i>		d. STREET ADDRESS <i>7713 Carroll Avenue</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	" <i>First Baby</i> "	Middle <i>Magas(m)</i>	4. DATE OF DEATH Month <i>12 27 1967</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White Caucasian</i>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-27-67</i>		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b KIND OF BUSINESS OR INDUSTRY <i>-</i>	9. AGE (In years last birthday) yrs <i>9 12</i>		
13. FATHER'S NAME <i>Kenneth A. Magas</i>		14. MOTHER'S MAIDEN NAME <i>Rita L. Goxon.</i>	12. CITIZEN OF WHAT COUNTRY? <i>Address</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>	17. INFORMANT <i>Father (chart) - same as above</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>In maturity - Neonatal Death</i>					
DUE TO <i>776X</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <i>lost</i>					
DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Am 12/27, 1967</i> , to <i>12/27, 1967</i> , that (I) (we) last saw the deceased alive on <i>12/27/67 - 1m 19</i> , and that death occurred at <i>6:30 PM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>Frank W. Neuberger</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/28/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>FRANK W. Neuberger</i>		22d. ADDRESS <i>1110 Spring St. S. L. Sprg. Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Jan. 2, 1968</i>		23b. DATE THEREOF <i>Jan. 2, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. James</i>	23d. LOCATION (City or Town) (County) (State) <i>New Haven Conn.</i>	
24. FUNERAL DIRECTOR <i>W.W.C. Chambers Inc</i>		ADDRESS <i>8655 Go Ave S. L. Sprg. Md.</i>	25a. REC'D BY REGISTRAR DATE <i>JAN 2 1968</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Chambers</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17291

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus	
3 NAME OF DECEASED (Type or print) Arthur J. Martineau		First Arthur	Middle J.
4 DATE OF DEATH Dec. 21 1967		Last 	Month Dec.
5 SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8 DATE OF BIRTH Sept. 16, 1895		9 AGE (In years lost birthday) 72 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11 BIRTHPLACE (County & State, or foreign country) Montague, Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Honorina Martineau		14. MOTHER'S MAIDEN NAME Georgianna Gorno	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. W.W. # 1 578-01-6548	
17. INFORMANT Mrs Mary Louise Martineau, Item 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Advanced Arteriosclerotic Cardio-Vascular Disease with Multiple Cerebral Thrombi		INTERVAL BETWEEN ONSET AND DEATH 1 month	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO 			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) No injury	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 		(County) 	
		(State) 	
21. I certify that (I) (this hospital) attended the deceased from November , 19 66 , to December 21 1966 , that (I) (we) last saw the deceased alive on December 21 1966 , and that death occurred at 8:05AM from causes and on the date stated above.		22b. DATE SIGNED December 22, 1967	
22c. SIGNATURE M. McKendree Boyer, M.D.		22d. ADDRESS 9701 Church Street Damascus, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 23, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven
23d. LOCATION (City or Town) Silver Spring, Md.		(County) 	
		(State) 	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		ADDRESS 	25a. RECD BY REGISTRAR DEC 27 1967
			25b. REGISTRAR'S SIGNATURE ent. by judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH								17297					
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b University Nursing Home		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		e. STREET ADDRESS 111 Seaton Pl. N.W.		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 901 Arcola Ave.													
3. NAME OF DECEASED (Type or print) Eva		First Mary	Middle Mason	Last 12/17/1889	4. DATE OF DEATH Month Dec.	Month 31	Day 1967						
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/17/1889	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	IF UNDER 24 HRS Hours 0	IF UNDER 24 HRS Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sundrey Catcher & Feeder		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Williamston, No. Carolina		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Rogers		14. MOTHER'S MAIDEN NAME Bassie Scott											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-03-0668		17. INFORMANT		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4221		DUE TO General aging process + Dementia		INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, wh ch gave rise to immediate cause (a), stating the underlying cause last (b) (c)													
PART II. OTHER SIGNIFICANT COND.TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) Lincoln Mem. Cem.		20f. (City or town) Suitland, Maryland		(County) Maryland		(State)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19													
21. I certify that (I) (this hospital) attended the deceased from 9/1/1967 to 12/27/1967 , that (I) (we) last saw the deceased alive on Dec. 27 1967 , and that death occurred at M , from causes and on the date stated above													
22a. SIGNATURE Russell G. Bufalino		22b. DATE SIGNED Dec 31 1967											
22c. PHYSICIAN'S NAME (Type) Russell G. Bufalino		22d. ADDRESS 1820-9th St. N.W. Washington, D.C.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-3-68		23c. NAME OF CEMETERY OR CREMATORIAL LINCOLN MEM. CEM.		23d. LOCATION (City or Town) SUITLAND, MARYLAND		(County) MARYLAND		(State)			
24. FUNERAL DIRECTOR Robert G. McGuire		ADDRESS 1820-9th St. N.W. Washington, D.C.		25a. REG'D BY REGISTRAR JAN 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death. Page 4 may be returned by the hospital or attending physician.

Cleared With Medical Examiner

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
Montgomery				Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	
Silver Spring				Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Holy Cross Hospital		1207 Carlton St.,		15	
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
Earl			May	December	31 19 67
SEX Male	6. COLOR OR RACE Cau	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH Feb 3, 1908	9. AGE (In years last birthday) 59 yrs
					IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Notions		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
Retail Store Owner				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isador May					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-24-0866		17. INFORMANT Leah May, same as 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) DUE TO Atherosclerosis last. } (c) DUE TO Hypercholesterolemia. INTERVAL BETWEEN ONSET AND DEATH at once 10 yrs 10 yrs					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1957	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1957 to 1962, that (I) (we) last saw the deceased alive on 12/25 1967, and that death occurred on 3/3/67 A.M. from causes and on the date stated above					
22a. SIGNATURE <i>Cyril A. Schuiman</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/3/67	
22c. PHYSICIAN'S NAME (Type) Cyril A. Schuiman		22d. ADDRESS 916-19th St N.W. Washington D.C.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1-2-1968		23c. NAME OF CEMETERY OR CREMATORIAL National Memorial Park	
24. FUNERAL DIRECTOR Goldberg Funeral Home		ADDRESS 4217 - 9th St. N.W.		25a. RECD BY REGISTRAR DATE 3/3/68	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1967-1971

1967-1971

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY MONTGOMERY						2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL HALL SANITARIUM						d. STREET ADDRESS 3200 16th STREET N.W.								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) DAISY			First S. Middle MAYFIELD			Last			4. DATE OF DEATH DECEMBER 30 1967	Month	Day	Year		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 15, 1881		9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		
10a. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME				11. BIRTHPLACE (County & State, or foreign country) MISSISSIPPI				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME D.D. STEPHENSON						14. MOTHER'S MAIDEN NAME ANNIE SHINN								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 577-07-2066				17. INFORMANT NURSINGHOME RECORDS				Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 586x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						<i>GCHD myocarditis</i> <i>cholecystectomy</i>						INTERVAL BETWEEN DEATH AND AUTOPSY 2 DIO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) artery sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Name, farm, factory, street office bldg., etc.)			20f. (City or town) Bethesda (County) Montgomery (State) M.D.					
21. I certify that (I) (this hospital) attended the deceased from Oct 29 1967 to Dec 30 1967 , that (I) (we) last saw the deceased alive on Oct 29 1967 , and that death occurred at 725 N. Biltmore St. N.W. from causes and on the date stated above.														
22a. SIGNATURE <i>E. Quayle</i>						22b. DATE SIGNED 12-30-67								
22c. PHYSICIAN'S NAME (Type) E. Quayle						22d. ADDRESS 1822 Biltmore St. N.W.								
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION			23b. DATE THEREOF 12/30/67			23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CREMATORY			23d. LOCATION (City or Town) (County) (State) BLADENSBURG (P.G. Co.) MD.					
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS INC. 5130 WISC. AVE N.W.						ADDRESS WASHINGTON, DC 25a. REC'D BY REGISTRAR JAN 5 1968 25b. REC'D BY SUPERINTENDENT <i>James J. Quayle</i>								



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c LENGTH OF STAY IN lb <i>5 yrs 10 days</i>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>All States Hotel</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Kensington Gardens SANITORIUM</i>		e. STREET ADDRESS <i>Washington, D.C.</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <i>MAX</i>		First <i>C.</i>	Middle <i>Mc CAFFREY</i>	Last <i>12.</i>	4. DATE OF DEATH <i>25</i>	Month <i>1967</i>	Day <i>Year</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 26 1870</i>	9. AGE (In years last birthday) yrs <i>97</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 RS Days <i></i>	12. Hours <i></i>
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gov. employee</i>		10b. KIND OF BUSINESS DR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Hugh Mc Caffrey</i>		14. MOTHER'S Maiden Name <i>JAN Spring Kennedy</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>579-60-2228</i>		16. SOCIAL SECURITY NO <i>Washington, D.C.</i>	
17. INFORMANT <i>E. Murray Norman-17th. & H. St. N.W.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4COX</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Influenza</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
DUE TO <i>Pneumonia</i>		DUE TO <i>Influenza</i>		5 days.			
DUE TO <i></i>		DUE TO <i></i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriosclerosis</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 24</i> , 1967, to <i>Dec 25</i> , 1967, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>Dec 24</i> , 1967, and that death occurred at <i>7:00 AM</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>Michael R. Dobridge</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>Dec 25 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Michael R. Dobridge</i>		22d. ADDRESS <i>12600 Parkland Drive, Rockville, Md.</i>					
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/29/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Congressional Cem.</i>		23d. LOCATION (City or Town) <i>Washington, D.C.</i>	(County) <i></i>	(State) <i></i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		ADDRESS <i>1331 Rock. Pike Rockville, Md.</i>	25a. RECD BY REGISTRAR DATE <i>JAN 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												11296
1 DECEASED NAME (Type or Print)		First <i>Donald</i>	Middle <i>H.</i>	Last <i>McAllum</i>	2a DATE KNOWN OF ESTI. DEATH MATED	Month <i>Dec</i>	Day <i>30</i>	Year <i>1967</i>	2b HOUR <i>M</i>			
3 SEX <i>Male</i>	4 RACE <i>Cauc</i>	5 DATE OF BIRTH <i>1888 May 1 1900</i>	6 AGE (in years last birthday) <i>70 yrs</i>	F UNDER 1 YEAR MONTHS <i>0</i>	F UNDER 24 HRS DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i>	MIN <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>January</i>	Day <i>19</i>	Year <i>19</i>	2d HOUR <i>M</i>	
7a BIRTHPLACE (State or foreign country) <i>Illinoi</i>		7b. CIT ZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Silver Spring</i>				
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>15 Hamilton Street</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Salesman</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Paint</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Illinoi</i>		13b COUNTY <i>Montgomery Co.</i>		13c CITY OR TOWN <i>Montgomery</i>	13d INSIDE CITY, MUNI?	YES <input checked="" type="checkbox"/>	<i>[Redacted]</i>	13e STREET AND NUMBER <i>15 Hamilton St.</i>	13f	13g		
14. FATHER'S NAME First <i>William</i>		Middle <i>McCallum</i>	Last <i></i>	15 MOTHER'S MAIDEN NAME First <i>Alice</i>		Middle <i>Bishop</i>	Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO (If yes give war or dates of service) <i>487-03-2047</i>		17. INFORMANT <i>John C. Bishop 15 Hamilton St.</i>		ADDRESS <i>Illinoi, U.S.A. 15 Hamilton St.</i>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> <i>Arteriosclerotic Heart Disease</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?						
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												22b DATE SIGNED <i>12-31-1967</i>
ACTUAL SIGNATURE <i>Belden R. Reap</i>		EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D. Rockville</i>		CHIEF MEDICAL EXAMINER M.D.		ASSISTANT MEDICAL EXAMINER M.D.		DEPUTY MEDICAL EXAMINER M.D.		ADMITTED TO (Hospital, County, City, town, etc.)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan. 3, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) <i>Rockville, Montg. Md.</i>		(County) <i>Montgomery County</i>		(State) <i>Md.</i>		
24. FUNERAL DIRECTOR <i>Warren E. Pumphrey, Inc. Silver Spring, Maryland</i>		ADDRESS <i>Glen Carter 8434 Ga. Ave</i>		REC'D BY REGISTRAR <i>JAN 8 1968</i>		REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17297

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>200 ft</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	
3. NAME OF DECEASED (Type or print) <i>S. JAY MCCARTHY</i>		First <i>S.</i>	Middle <i>JAY</i>
4. DATE OF DEATH <i>Dec. 10 1967</i>		Lost <i>McCARTHY</i>	Month Day Year Dec. 10 1967
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec. 15-1894</i>		9. AGE (in years last birthday) <i>75 yrs</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington - DC</i>	
12. CITIZEN OF WHAT COUNTRY <i>USA</i>		13. FATHER'S NAME <i>Sullivan Jay McCarthy Sr.</i>	
14. MOTHER'S MAIDEN NAME <i>Estes - Frances Josephine</i>		15. SOCIAL SECURITY NO. <i>577-54-1410</i>	
16. INFORMANT <i>Mr. & Mrs. McCarthy Jr. 4606 Garrison St</i>		17. ADDRESS <i>They Chase - Mt.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
Acute coronary occlusion Coronary arterio-sclerosis INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Emphysema</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>
21. I certify that (I) (this hospital) attended the deceased from <i>May 1967</i> , to <i>2-10, 1967</i> , that (I) (we) last saw the deceased alive on <i>12-5-1967</i> , and that death occurred at <i>9:03 PM</i> , from causes and on the date stated above			
22a. SIGNATURE <i>Russell M. Tilley, Jr.</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22b. DATE SIGNED <i>12-10-67</i>
22c. PHYSICIAN'S NAME (Type) <i>RUSSELL M. TILLEY</i>		22d. ADDRESS <i>4701 MASS. AVENUE N. W., WASHINGTON DC</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) CREMATION <i>12/11/67</i>		23b. DATE THEREOF <i>12/11/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR HILL</i>
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SONS, 5130 WIS. AVE. N.W. WASH.</i>		ADDRESS <i>DATA</i>	25a. REC'D BY REGISTRAR <i>DEC 15 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17298

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver springs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 8610 Manchester Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Tracy L. Mc Cauley		First	Middle	Last	4. DATE OF DEATH 12	Month	Day Year 4 19 67
S. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 4 Jan 1887	9. AGE (in years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A.H. Mc Cauley				14. MOTHER'S MAIDEN NAME Ida Lay			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) (If yes give war or dates of service) YES Unknown		16. SOCIAL SECURITY NO. 665 16 8062A		17. INFORMANT Helen Baird apt 1208, Silver Springs, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) +341 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Edema		Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 21 November, 1967, to 4 December 1967, that (I) (we) last saw the deceased alive on 4 December 1967, and that death occurred at 0630 AM, from causes and on the date stated above							
22a. SIGNATURE <i>Lucene A. Kaplan</i>		22b. DATE SIGNED 4 January 1967					
22c. PHYSICIAN'S NAME (Type) S. Kaplan, LCDR MC USN		22d. ADDRESS Naval Hospital Bethesda Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7 DEC 1967		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR <i>Joseph Fowler & Sons</i>		ADDRESS 5130 Wisconsin Ave, Washington D.C.		25a. RECD BY REGISTRAR DATE DEC 11 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17299

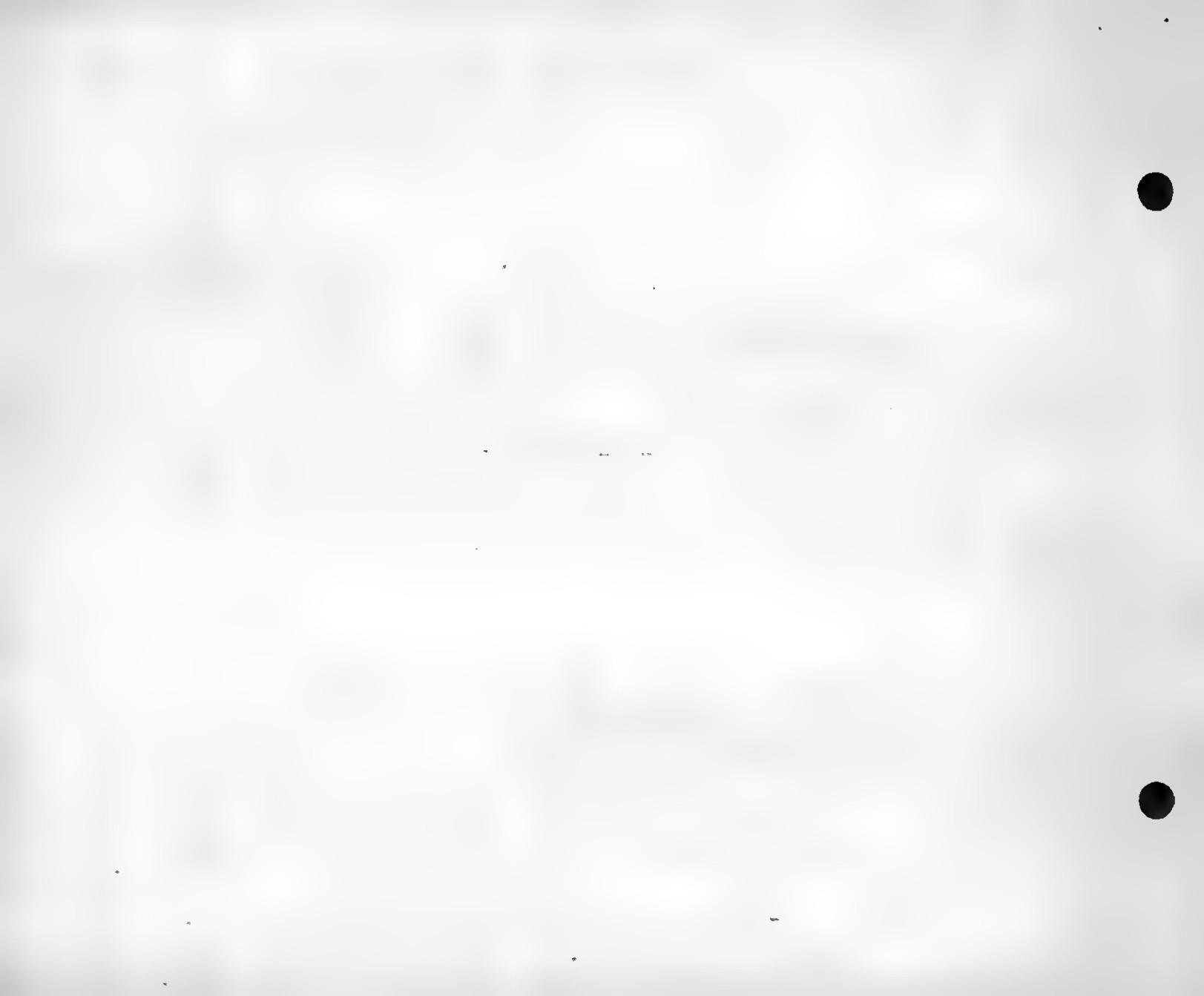
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Health Department. File pages 1 and 2 with the funeral director. File pages 1 and 2 with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Maryland</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c LENGTH OF STAY IN 1b <i>3 hr 30 min</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sullivan</i>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d STREET ADDRESS <i>1040, Limestone, Place</i>		f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>M. Adred</i>		First <i>Nice</i>	Middle <i>F.</i>
		Last <i>Alexley</i>	4 DATE OF DEATH <i>December 2 1967</i>
5. SEX <i>Fe</i>		6 COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>J Edward Fowler</i>		14. MOTHER'S Maiden Name <i>Mae AARON</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>215-46-2533</i>	
17. INFORMANT <i>Dorothy P. (Patti) Winkler</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage - N. S. S. i.e.</i> DUE TO <i>4221</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio Vascular Disease</i> DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH <i>461</i>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Bethesda</i> (County) <i>Maryland</i> (State) <i>Md</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-5-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Parklawn Cemetery</i>
23d. LOCATION (City or Town) <i>Rockville</i> (County) <i>Maryland</i> (State) <i>Md</i>		23e. REC'D BY REGISTRAR <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR ATSM (5) GM 1/67		DATE <i>DEC 8 1967</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17300

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>	
d. LENGTH OF STAY IN b <i>20 Minutes</i>		e. STREET ADDRESS <i>9902 Inglemere Dr.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Robert C. MELENNEY</i>		First	Middle
4 DATE OF DEATH <i>DEC 29 1967</i>		Month	Day Year
S SEX <i>M</i>	5. COLOR OR RACE <i>W</i>	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	7. NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>DEC 10-1915</i>		9. AGE (in years (last birthday) yrs <i>52</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MECHANICAL Eng Reli</i>		11. KIND OF BUSINESS OR INDUSTRY <i>Riley Stoker Corp</i>	12. C ITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Robert C. MELENNEY</i>		14. MOTHER'S MAIDEN NAME <i>Stephanie CLARK</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>YES. 1941 - 1946</i>		16. SOCIAL SECURITY NO. <i>315-10-8415</i>	17. INFORMANT (Wife) Address <i>Jane A MELENNEY Same</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
3561 Due to Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost		Acute Respiratory Failure 30 MIN	
Due to (b) <i>AMYOTROPHIC LATERAL SCLEROSIS</i>		4 YRS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <i>9</i>
20f. (City or town) <i>Dec 29, 1967</i>		(County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>DEC 29, 1967</i> to <i>DEC 29, 1967</i> , that (I) (we) last saw the deceased alive on <i>DEC 29, 1967</i> , and that death occurred at <i>11:52 AM</i> , from causes and on the date stated above			
22a. SIGNATURE <i>Robert G. Angle</i>		22b. DATE SIGNED <i>Dec 30, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert G. Angle</i>		22d. ADDRESS <i>5009 Del Ray Ave. Bethesda, Maryland</i>	M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Jan 2 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>
23d. LOCATION (City or Town) <i>Suitland</i>		(County) (State) <i>Pr. Geo Md</i>	
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>		25a. REC'D BY REGISTRAR <i>Charles George</i>	25b. REGISTRAR'S SIGNATURE <i>Charles George</i>
25b. ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>		DATE JAN 5 1968	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

PAGE 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		11301	
O. COUNTY	Montgomery	MARYLAND	2 USUAL RESIDENCE (Where deceased resided, if institution, residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Takoma Park	-	O STATE	Maryland	b. COUNTY	Prince Georges	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Washington San. + Hospital		d. STREET ADDRESS	Adelphi		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First A.	Middle Russell	Last Miller	4. DATE OF DEATH	Month December	Day 17	Year 1967
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min	
Male	white		DIVORCED <input type="checkbox"/>	1-2-05	62 yrs		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
	Rixon Electronics		Pennsylvania		U.S.A.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		Address				
Clayton Miller	Lavinia Pierce		Hospital Records				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH			
			Hospital Records	HEMORRHAGE DAYS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 5410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost	Massive gastrointestinal hemorrhage		?				
(b) DUE TO STRESS ULCERS OF STOMACH	(c) PERITONITIS		WEEKS				
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Homologous serum hepatitis, chronic bronchitis, emphysema							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) attended the deceased from 11-7-67, 1967, to 12-7-1967, and that death occurred at 7:40 AM, from causes and on the date stated above saw the deceased alive on 12-10-1967, and that death occurred at 7:40 AM, from causes and on the date stated above	22b. DATE SIGNED 12-18-67						
22a. SIGNATURE Leonard L. Deit	M.D. ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS 111 Spring St. SILVER SPRING, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 12-19-67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS EGO. Univ. Med. Sch.	23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.				
24. FUNERAL DIRECTOR James E. Dugdale - 2223 Wisconsin Ave., N.W. - Wash. D.C.	ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 2 1968	25b. REGISTRAR'S SIGNATURE Cleaning wife			



Items 18&21 Film 398 MARYLAND STATE DEPARTMENT OF HEALTH
3-11-68 a.m.s DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17302

1 PLACE OF DEATH a. COUNTY MONTGOMERY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	c. LENGTH OF STAY IN lb DOA	b. COUNTY MONTGOMERY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANATORIUM & HOSPITAL		d. STREET ADDRESS 1412 HAMPSHIRE WEST COURT	
3 NAME OF DECEASED (Type or print) BRENDA GAY MILLER	First BRENDA	Middle GAY	Last MILLER
4 DATE OF DEATH 12 8 1967	Month 12	Day 8	Year 1967
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
8 DATE OF BIRTH 6-29-45	9 AGE (In years last birthday) 22 yrs	F UNDER 1 YEAR Months 0	F UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE	10b. KIND OF BUSINESS OR INDUSTRY Nursing	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Miller	14. MOTHER'S MAIDEN NAME Loretta Layne		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. Yes	17. INFORMANT PEGGY ADER	Address SAME
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute, severe, bilateral, DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhagic, bronchopneumonia DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 19		20g. (County) West Virginia	20h. (State) West Virginia
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Rearp</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> D.P.L. M.D.		
22. DATE SIGNED DEC. 8, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 12, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Mountain View Memorial Gardens	23d. LOCATION (City or Town) Maher, West Virginia
24. FUNERAL DIRECTOR John Thomas Warner E. Pumphrey, Inc.	ADDRESS 8434 Ga. Ave., Silver Spring, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
25a. DATE DEC 13 1967	25b. DATE DEC 13 1967		

64

1. *C. c. cincta* *var. cincta*

Differs from *C. c. cincta* in having a more basal perianth lobe
and a larger perianth.

2. *C. c. cincta* *var. cincta*

Differs from *C. c. cincta* in having a more basal perianth lobe
and a larger perianth.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 63 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lynchburg	b. COUNTY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md.		d. STREET ADDRESS 1000 Wise Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nellie	First Erna	Middle Millner	Last Month December Day 27 Year 1967
4. DATE OF DEATH			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. DATE OF BIRTH 27 September	
10. KIND OF BUSINESS OR INDUSTRY ---		9. AGE (In years last birthday) 40 yrs	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard G. Eagle		14. MOTHER'S MAIDEN NAME Pearl J. Phelps	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 227-22-9378	
17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Chronic Myelogenous Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 1 day	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 25 October 1967, to 27 Dec. 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 27 December 1967, and that death occurred at 8:48 M, from causes and on the date stated above.		22b. DATE SIGNED 1967	
22a. SIGNATURE Bruce Chabner		PM	
22c. PHYSICIAN'S NAME (Type) Bruce Chabner, MD		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 30, 1967	23c. NAME OF CEMETERY OR CREMATORIAL EAGLE FAMILY CEMETERY
23d. LOCATION (City or Town) (County) (State) APPOMATOX COUNTY, VIRGINIA		25a. REC'D BY REGISTRAR DATE JAN 2 1968	
24. FUNERAL DIRECTOR WHITTEN FUNERAL HOME, INC. LYNCHBURG, VA.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17304

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>7 days</i>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>15105 Peach Orchard Rd</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San. & Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Mary Alberta Milstead</i>		First	Middle	
4. DATE OF DEATH	Month <i>12</i>	Day <i>20</i>	Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>9-8-02</i>	9. AGE (in years last birthday) <i>65 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George W. Mills</i>	14. MOTHER'S MAIDEN NAME <i>Rosie Williams</i>	Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No</i>	16. SOCIAL SECURITY NO <i>578-46-5191</i>	17. INFORMANT <i>Hospital Records</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Wide spread metastatic carcinoma</i> DUE TO DUE TO (c) <i>breast - Pulmonary & osseous</i>	INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1967</i> , to <i>12-20, 1967</i> , that (I) (we) last saw the deceased alive on <i>12-19, 1967</i> , and that death occurred at <i>Burtonsville, Md.</i> from causes and on the date stated above.				
22a. SIGNATURE <i>Joseph E. Smith Jr.</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12-20-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Joseph E. Smith Jr. M.D.</i>		22d. ADDRESS <i>Burtonsville, Md.</i>		
23a. BURIAL, CREMATION, REMOVALS (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 23, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Burtonsville Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Burtonsville, Md.</i>
24. FUNERAL DIRECTOR <i>John P. Warner & Son, Inc.</i>		24b. ADDRESS <i>3434 Georgia Ave. Silver Spring, Md.</i>	25a. REC'D. BY REGISTRAR DATE <i>DEC 27 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

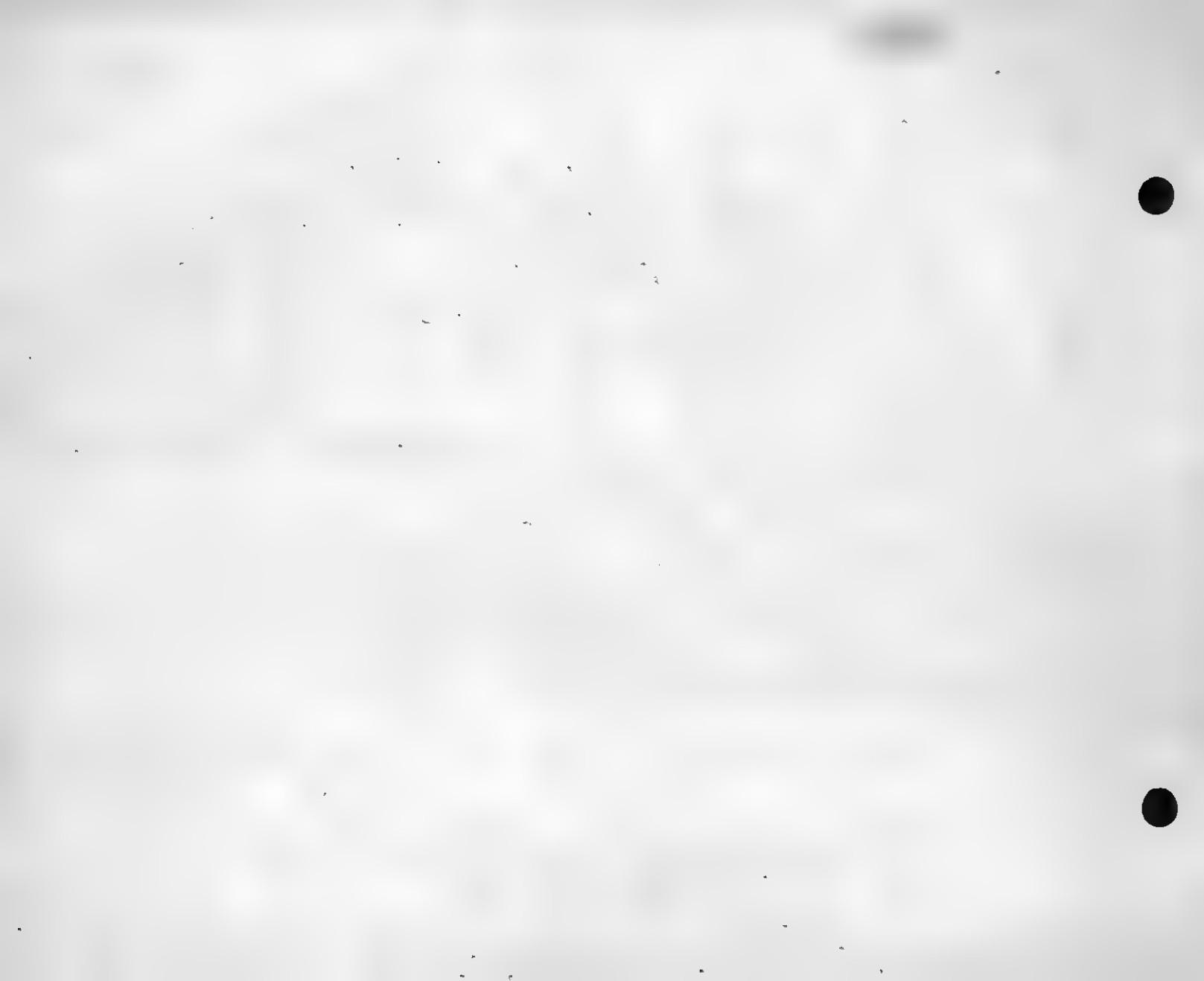
CERTIFICATE OF DEATH

17305

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 16 20 days/13 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hawthorne	
f. STREET ADDRESS 1721 Merrimac Dr.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alvin Ernest Mitchell		4. DATE OF DEATH Month DEC Day 6 Year 1967	
S SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10-3-99		9. AGE (In years last birthday) 68 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpentry	
11. BIRTHPLACE (Country & State, or foreign country) Ashville, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oscar Mitchell		14. MOTHER'S MAIDEN NAME Ellen Merrill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-10-6732	
17. INFORMANT Alvin R. Mitchell		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first UREMIA		DUE TO (b) CHRONIC CAR PULMONAL DUE TO (c) PULMONARY EMPHYSEMA	
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) UREMIA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21. I certify that (1) (this hospital) attended the deceased from 11/11, 1967 to 12/6, 1967 that (1) (we) last saw the deceased alive on 12/6, 1967, and that death occurred at 8:30 PM, from causes and on the date stated above.	
20f. (City or town) 22a. SIGNATURE Dr. N. Dublin		(County) (State)	
22b. DATE SIGNED 12/6/67			
22c. PHYSICIAN'S NAME (Type) Ira N. Dublin		22d. ADDRESS 800 PERSHING, DR. S.S. M.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 11, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Mausoleum		23d. LOCATION (City or Town) Prince Georges, County, Md.	
24. FUNERAL DIRECTOR Glen Carter		25a. RECEIVED BY REGISTRAR DEC 11 1967	
24b. ADDRESS Warner C. Pumphrey, Inc. Silver Spring, Md.		25b. REC'D. BY S. SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

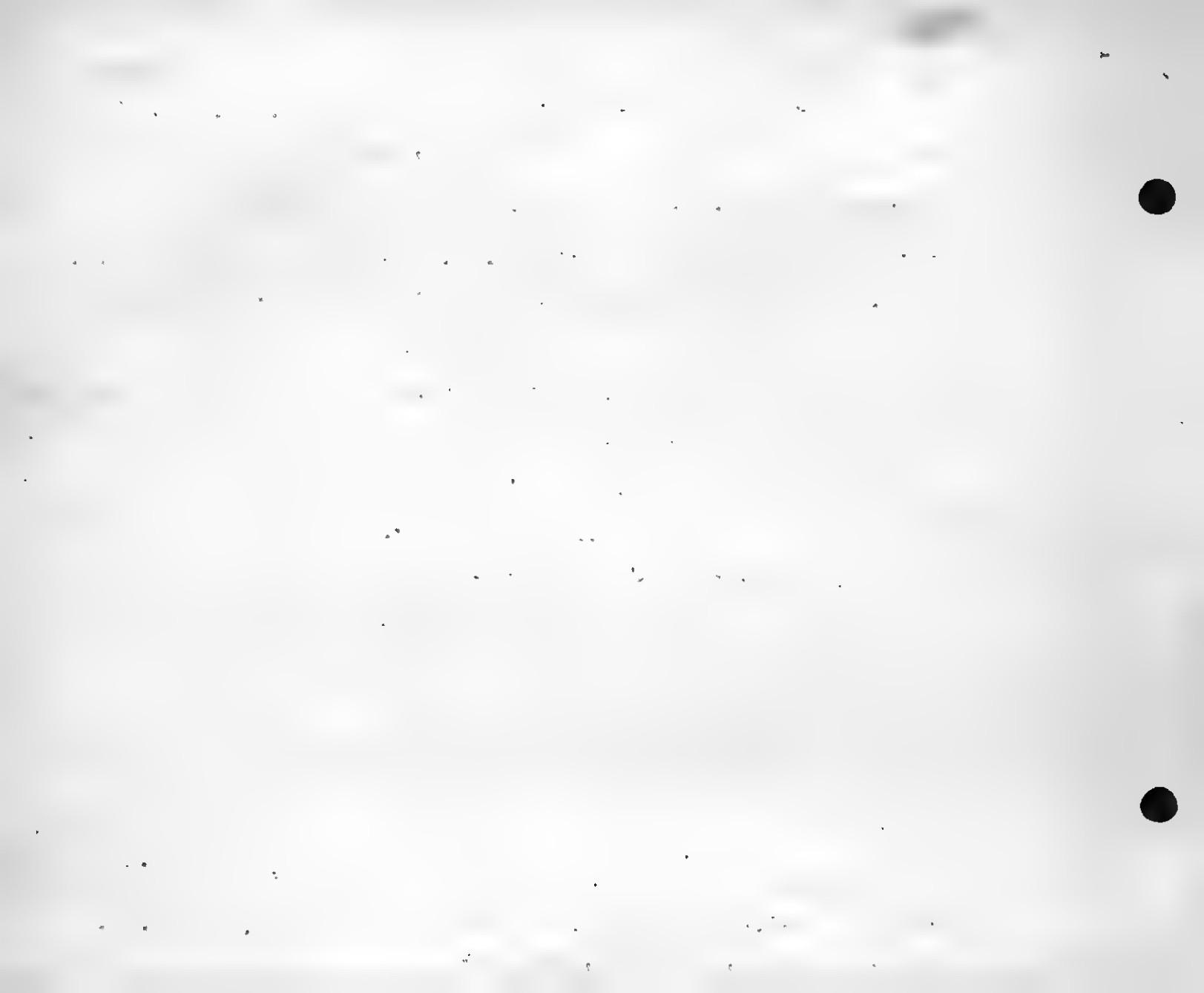
306

17306

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR 10 ¹² P.M.
				EDWARD	GERARD	MONTGOMERY	Dec. 20,				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		May 10, 1878		89		MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9 COUNTY OF DEATH			
Nebraska		U. S.		<input checked="" type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED		Montgomery			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Potomac Valley N. H.				Economist				U.S. Govt	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md.		Montgomery Chase		<input checked="" type="checkbox"/> YES		<input type="checkbox"/> NO		24 W. Kirke Street			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
					Elizabeth Mooney						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
No		Unknown		Nancy Montgomery		Same as Item 1a.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (o) Respiratory Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
11/11/67											
Diseased											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) Carcinomatosis 2 more											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Cancer, the Prostate 5 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)											
Arteriosclerotic Heart Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1961, 1961, to Dec., 1967, that (I) (we) last saw the deceased alive on Dec. 13, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		M. D.		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		William H. K. H.		22e. ADDRESS		Dec. 21, 1967					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)	
Burial		12-22-67		Rock Creek Cemetery		Washington, D. C.					
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
ROBERT A. PUMPHREY, Bethesda, Maryland				DEC 26 1967							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If legal and 2 director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

17307

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>71 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d. STREET ADDRESS <i>7518 Carroll Avenue</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washingtonian San & Hospital</i>				e. 5. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Pauline</i>		First <i>(none)</i>	Middle <i>(none)</i>	Last <i>Moore</i>	4. DATE OF DEATH <i>DEC.</i>	Month <i>7</i>	Doy <i>1967</i>
S. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-28-90</i>	9. AGE (in years lost birthday) <i>77 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>OFFICE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PUBLISHING</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Moore</i>		14. MOTHER'S MAREN NAME <i>Martha Barker</i>				Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-34-8744</i>		17. INFORMANT <i>Hospital Records.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>5810</i>		DUE TO <i>Loss of Liver</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1st week Aug 1966</i>			
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <i>Arterial</i>		(b) DUE TO <i>Arteria</i>				3 wks.	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Jan 22, 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Bethesda</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 22, 1967</i> , to <i>Dec 1, 1967</i> , that (I) (we) last saw the deceased alive on <i>12/1/67</i> , 1967, and that death occurred at <i>12/1/67</i> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Edward T. Moore</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.				22b. DATE SIGNED <i>12/1/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Edward T. Moore</i>		22d. ADDRESS <i>7030 Carroll Ave Takoma Park MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 9, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>George Washington Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Alexandria City, Va.</i>	
24. FUNERAL DIRECTOR <i>J. Andrew Lathers Washington, DC</i>		25a. ADDRESS <i>254 Carroll St. NW</i>		25b. DATE <i>12/1/67</i>		25c. REG'D BY REGISTRAR <i>Charles Judge</i>	
25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate he executed within 24 hours after death

Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>31 days</i>		d. STATE <i>Maryland</i> b. COUNTY <i>MONTGOMERY</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Saburbian</i>		e. STREET ADDRESS <i>18825 Georgia Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William</i>		First <i>A</i>	Middle <i>Moore</i>	4. DATE OF DEATH Month <i>Dec</i> Day <i>14</i> Year <i>1967</i>	
S SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>1/3/1896</i>	9. AGE IN YEARS (at time of death) Years <i>71</i>	F. UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Builder</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>		11. BIRTHPLACE (County & State, or foreign country) <i>District of Co.</i>	
13. FATHER'S NAME <i>John Moore</i>		14. MOTHER'S MAIDEN NAME <i>Helen Moore / Jane above</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>579-20-1855</i>		17. INFORMANT Address <i>Helen Moore / Jane above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cancer of prostate & spine, rib and liver metastases</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO (c) <i></i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>p.m.</i> 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i></i>	(County) <i></i> (State) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>11-13</i> , 19 <i>67</i> to <i>12-14</i> , 19 <i>67</i> ; that (I) (we) last saw the deceased alive on <i>12-13</i> , 19 <i>67</i> , and that death occurred at <i>11-14</i> M, from causes and on the date stated above					
22a. SIGNATURE <i>Benna G. Bender MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>12-14-67</i>		
22c. PHYSICIAN'S NAME (Type) <i>Benna G. Bender</i>		22d. ADDRESS <i>10820 Georgia Ave. Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, BURIED (if any) <i>Buried</i>		23b. DATE THEREOF <i>12/18/67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Wesley Grove Cemetery</i>	23d. LOCATION (City or Town) <i>Woodfield, Montgomery</i>	(County) <i></i> (State) <i></i>
24. FUNERAL DIRECTOR <i>Tyson Heeler Funeral Home</i>		ADDRESS <i>1351 Rockville Pike Rockville, Maryland</i>	RECD BY REGISTRAR <i>DEC 21 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



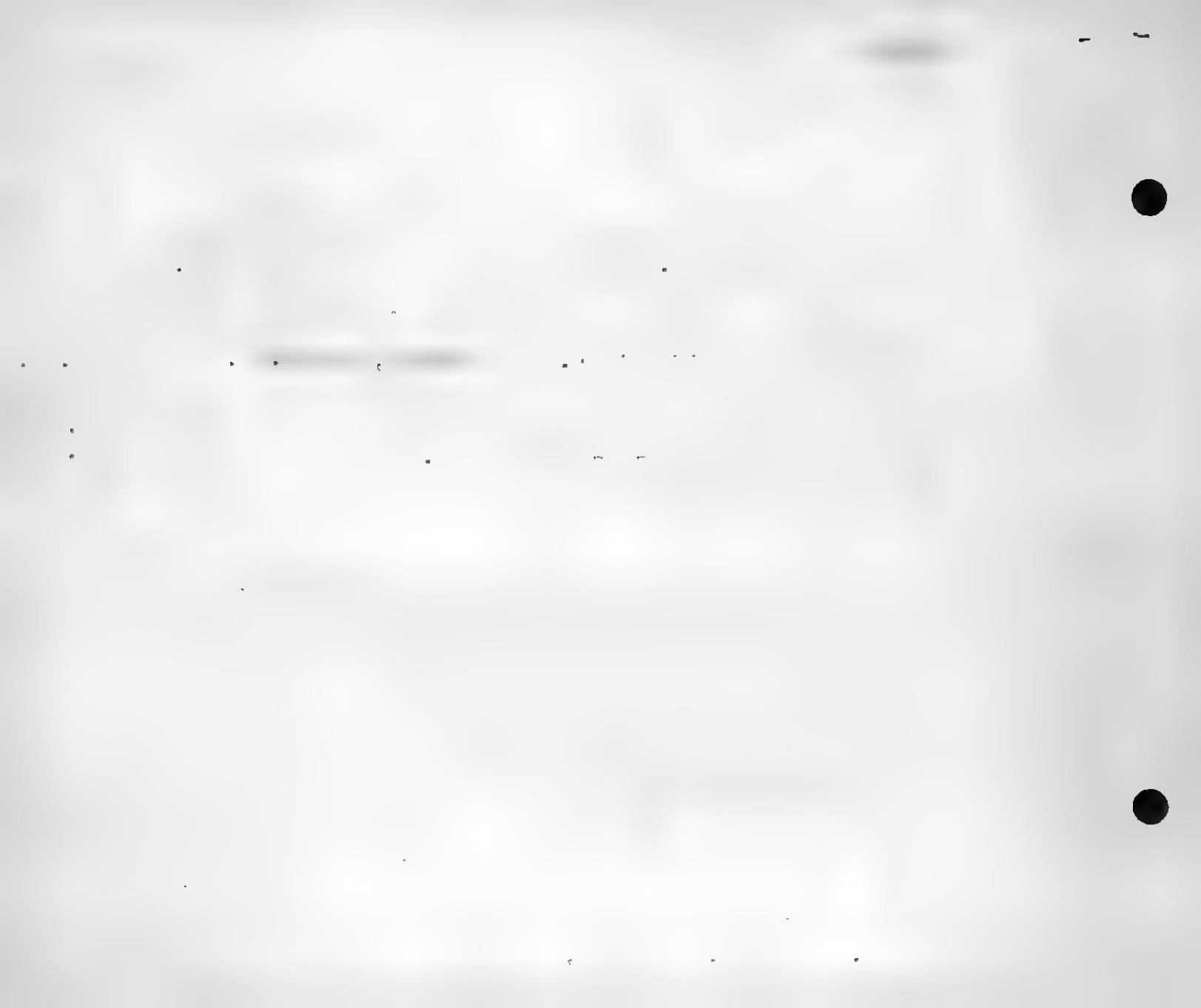
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN lb 3 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4900 Battery Lane		d. STREET ADDRESS 4900 Battery Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First MARGARET	Middle B.	Last MORGAN
4 SEX Female	5 COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 16, 1890	9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Transit Co.	
13. FATHER'S NAME Michael Barrett		14. MOTHER'S MAIDEN NAME Catherine Shields	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 578-10-6383	
17. INFORMANT Son		18. ADDRESS 7721 Marie Ave.	
		La Mesa, Calif.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town) Decatur (County) Georgia (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to 12-4-1967, that (I) (we) last saw the deceased alive on Dec 1 1967 , and that death occurred at 10 AM , from causes and on the date stated above.		22b. DATE SIGNED Dec 4 1967	
22a. SIGNATURE Stewart Clapp		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Stewart Clapp		22d. ADDRESS 4740 Chevy Chase Dr	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Gate of Heaven		23d. LOCATION (City or Town) Silver Spring, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE DEC 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles George	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

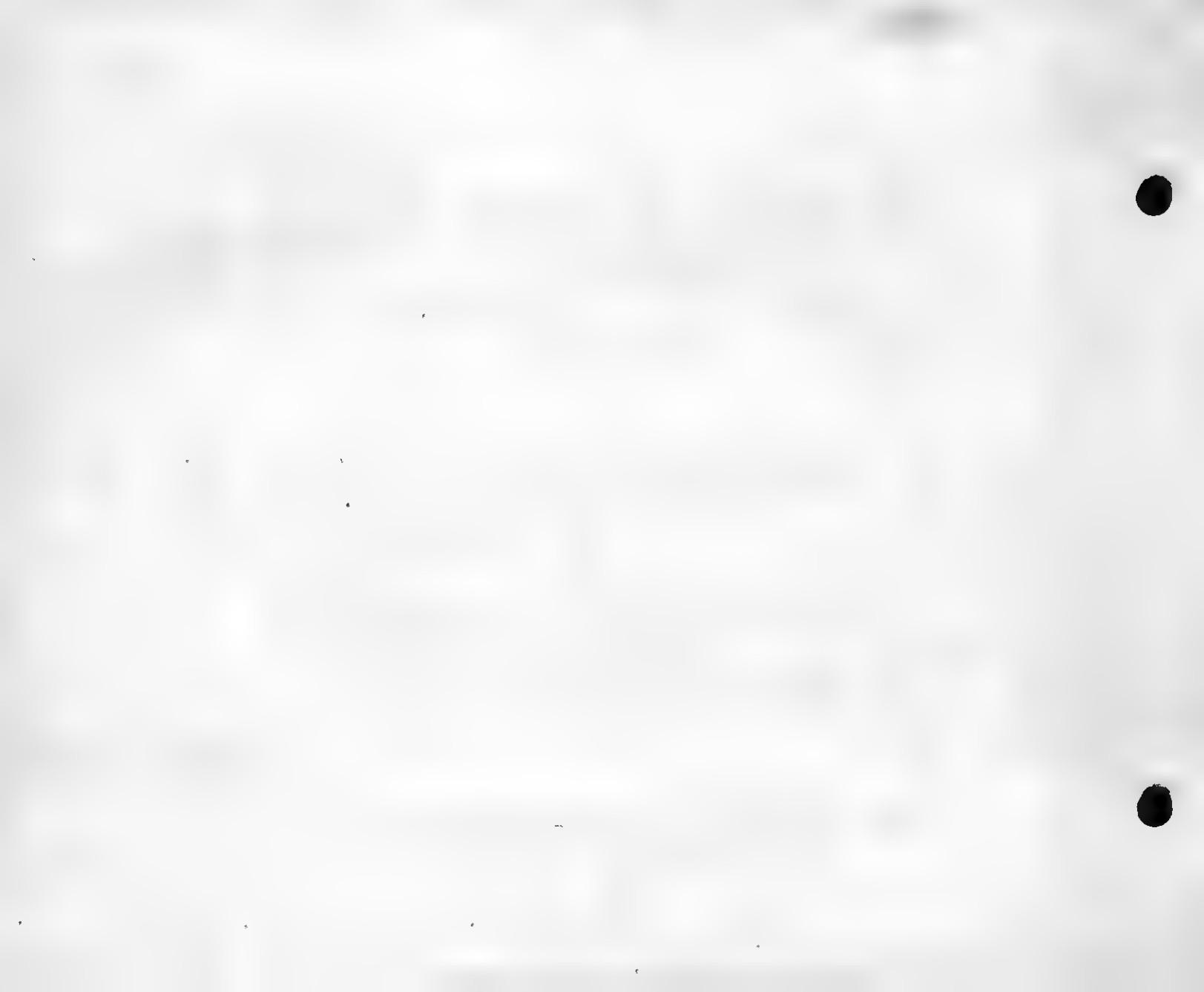
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. LENGTH OF STAY IN b MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEAT PLEASANT	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNIVERSITY NURSING HOME			d. STREET ADDRESS 712 Rollins Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOHN BRYANT MORRISON		First	Middle	Last	4. DATE OF DEATH Month Day Year DECEMBER 5 19 67
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT, 9, 1886	9. AGE (in years last birthday) 81 yrs
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY NURSERY		11. BIRTHPLACE (County & State, or foreign country) IOWA	
13. FATHER'S NAME JOHN E MORRISON			14. MOTHER'S MAIDEN NAME MARY BRYANT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO		17. INFORMANT EVELYN HEFLIN 407 ROLLINS AVE. SEAT PLEASANT	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cards -</i> DUE TO <i>Vascular Neural Disease</i> INTERVAL BETWEEN ONSET AND DEATH 44 x 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour am p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1955</i> to <i>Dec 5, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 5, 1967</i> , and that death occurred at <i>5:30 PM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>Wilhelm Bryant, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/5/67.		
22c. PHYSICIAN'S NAME (Type) <i>W M B R A T I N I W</i>		22d. ADDRESS <i>6124 Central Ave, Capitol Hgts MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/8/67	23c. NAME OF CEMETERY OR CREMATORIAL WASHINGTON NAT. CEMETERY SUITLAND, PRINCE GEORGES Md.	23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17311

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers, sign, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		f. STREET ADDRESS 10 SADDLE ROCK Ct		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Phillip		First O.	Middle 	Last MORRISON	4. DATE OF DEATH Month 12	Year 5 1967	Day 	Year 	
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/09	9. AGE (In years lost birthday) 59 yrs	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS. Days 	Hours 	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Couptroller		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Morrison		14. MOTHER'S MAIDEN NAME Leah Eisler							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unk.		16. SOCIAL SECURITY NO. 069-01-6574		17. INFORMANT Mrs. Anne Morrison (w)		Address 10 Saddle Rock Ct. S.S. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO (b)		Heart Failure - Arteriosclerotic HT As. Coronary atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 mo			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		DUE TO (d)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gout, Diabetes, mellitus, bronchitis		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on 12/14 1967 , and that death occurred at 11 AM , from causes and on the date stated above.									
22a. SIGNATURE Ira N. Tublin		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/5/67					
22c. PHYSICIAN'S NAME (Type) Ira N. Tublin		22d. ADDRESS 800 Pershing Dr. S. S. Md.							
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-6-67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS King David New Garden FALLS church, Virginia		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Bernard Danzansky + Sons		ADDRESS 3501/4 4th St. N.W.		25a. REC'D. BY REGISTRAR DEC 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
EARTH DEPT

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EXAMINER

DICAL EXECUTIVE DIRECTOR: PETER GOLDBURG

GENERAL DIRECTOR

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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First Cora	Middle Edna	Last Mowry	2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/>	Month Dec 31 1967	Day 67	Year 90	2b HOUR PM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 28 Feb 1877	6 AGE (in years last birthday) 90 yrs	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year Year 19			2d HOUR AM	
7a BIRTHPLACE (State or foreign country) Mich		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery				
10 CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospita give street address) Kensington Gardens			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY at home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MS Md		13b CITY OR TOWN Montgomery		13c COUNTY Kensington	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 10217 Summit Ave				
14. FATHER'S NAME Francis E		Middle Hadley	Last	15 MOTHER'S MAIDEN NAME Mary		First	Middle	Last	Foster	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 213-56-3079		17. INFORMANT Ruth M Woolley		ADDRESS 10217 Summit Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, Bilat.</i> 471X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) last DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <i>Belden R. Reap</i> M.D.										22b DATE SIGNED 1-1-1968
ACTUAL SIGNATURE <i>Belden R. Reap</i>		EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESSEES OF THIS CERTIFICATE (if any)		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Jan 6 1968		23c NAME OF CEMETERY OR CREMATORIUM Wixon Cemetery		23d LOCATION (City or Town) Wixon		(County) Mich	(State)	
24 FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 7557 Wisconsin Ave Bethesda, Md		25a REC'D BY REGISTRAR DATE JAN 5 1968		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

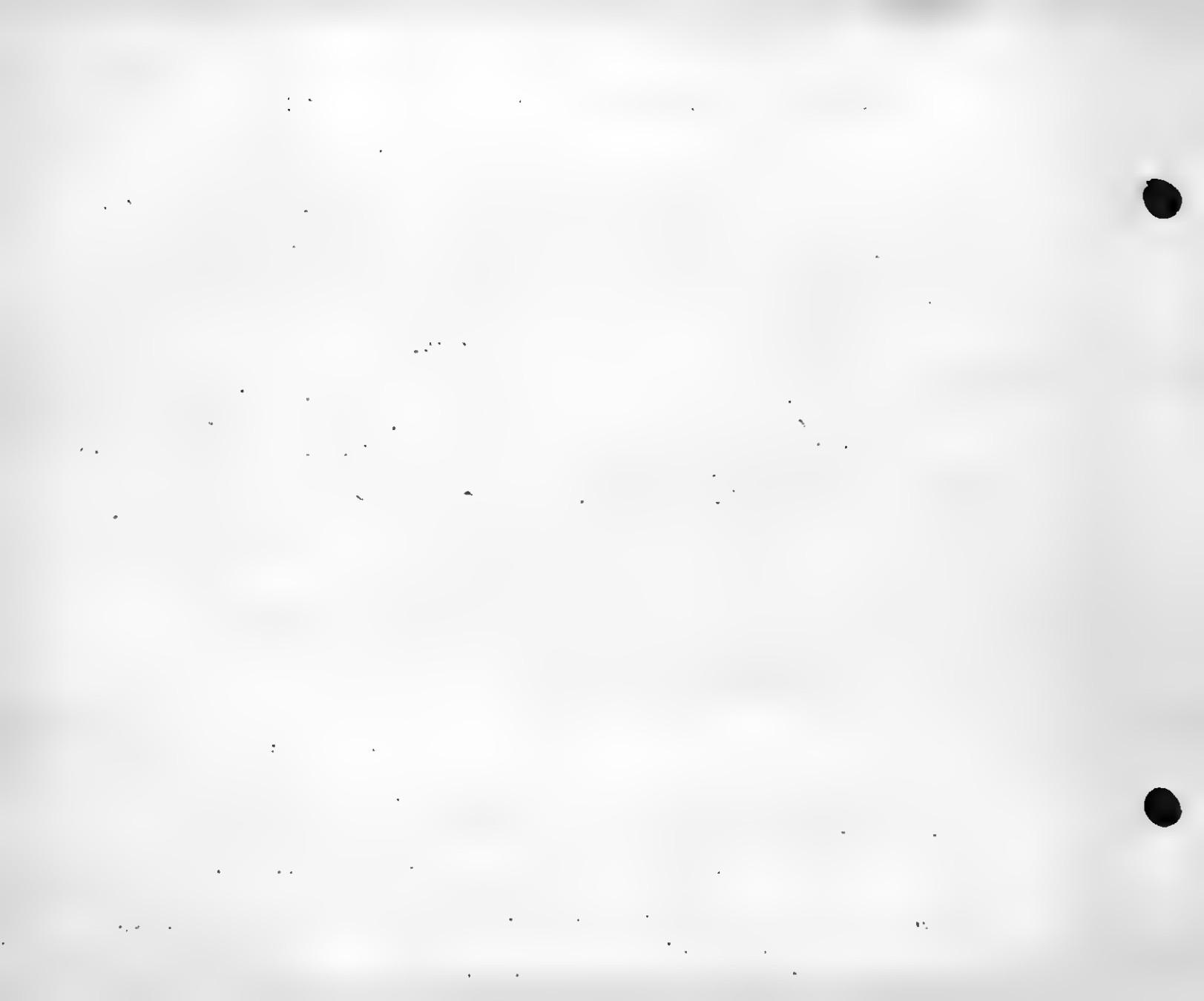
CERTIFICATE OF DEATH

7313

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, **please remove carbon paper**. Then **detach for use as the burial-transit permit**. Then **reinsert carbon paper**, **sign again**, and **refile with the State Dept. of Health prior to burial, cremation, or removal**.

1. DECEASED NAME (Type or print) Theresa	First Catherine	Middle Mulholland	Last	2a. DATE OF DEATH Dec 29 th 1967	2b. HOUR M
3. SEX Female	4. RACE White	S. DATE OF BIRTH June 11-1899	6. AGE (In years (at birthday) 88) YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Penn	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	10. d. Md.	
10. CITY OR TOWN OF DEATH Boyd's Rural	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife	12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Little Creek	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First John	Middle Hickey	Last	15. MOTHER'S M AIDEN NAME First Catherine	Middle Gorman	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO	17. INFORMANT John Mulholland. Boyd's (Rural) Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Lung (metastatic) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Carcinoma of Stomach DUE TO, OR AS A CONSEQUENCE OF (b) 1 year? (c) 1 year?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Sept. 15, 1967 to Dec. 29, 1967 , that (I) (we) last saw the deceased alive on Dec. 29, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. — 10 a.m.					
22b. SIGNATURE Jack Schumacher	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12-30-67	
22d. PHYSICIAN'S NAME (Type) Jack Schumacher	22e. ADDRESS Gaithersburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-2-68	23c. NAME OF CEMETERY OR CREMATORIAL Braddock Catholic	23d. LOCATION (City or Town) North Braddock, Alz.	(County) Penn	(State)
24. FUNERAL DIRECTOR Ernest C. Gartner	ADDRESS Gaines C. Gartner	25a. REC'D BY REGISTRAR DATE 1/1/68	25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.



If any death occurs between 12 m. and 2 p.m., give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief of Medical Examiner's Office along with form M-33. Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

D.O.B. Sept. 1, 1924 - 43 yrs.

Exhibit 8

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17314

1. PLACE OF DEATH a. COUNTY <i>Baltimore Md.</i>		2. USUAL RESIDENCE (Where deceased resided, if institution: Residence before admission) a. STATE <i>Maryland</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Md.</i>		c. LENGTH OF STAY IN b. <i>2 hrs.</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospice, give street address) <i>Suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie Md.</i>							
d. STREET ADDRESS <i>4806 Scarsdale Rd</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Edgar</i>	Last <i>Murdock</i>						
4. DATE OF DEATH	5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/>	9. DATE OF BIRTH <i>1877-1924</i>	10. AGE (In years for birthday) yrs <i>47</i>	11. UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>John for Murphy's Green Bay</i>	10c. BIRTHPLACE (State or foreign country), <i>Wisconsin</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>						
13. FATHER'S NAME <i>John Edgar Sr.</i>	14. MOTHER'S MARRIED NAME <i>Marion Sera Lynch</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No and town) (If yes, give war or dates of service) <i>Yes 1918-1918 DODN-037007</i>	16. SOCIAL SECURITY NUMBER <i>579-05-8445</i>	17. INFORMANT <i>Sam</i>	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple Injuries. Severe -</i>						INTERVAL BETWEEN INJURY AND DEATH <i>2 1/2 hr.</i>			
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last <i>Trauma from Auto Accident -</i>									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Had epileptic seizure while driving</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20c. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.) <i>Highway</i>	20f. (City or town) <i>Bethesda</i>	(County) <i>Montgomery</i>	(State) <i>Md.</i>
20e. TIME OF INJURY Month, Day, Year <i>2 1/2 p.m. 12/30 1967</i>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						22. DATE SIGNED <i>12/31/67</i>			
ACTUAL SIGNATURE <i>John G. Ball</i>		M.O.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>John G. Ball, M.D.</i>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/3/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cem.</i>		23d. LOCATION (City or Town) <i>Arlington</i> (County) <i>Virginia</i> (State)			
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., Wash., D.C.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>JAN 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



1 2 3 4 5

6 7 8 9 10 11 12

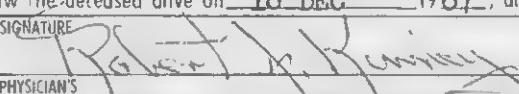
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17315

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

7315		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						17315											
1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND															
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN MD 2 Months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale		d. STREET ADDRESS 4819 Longfellow St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNH, NNMIC, BETHESDA, MD				e. DATE OF DEATH December 16 1967				Month Doy Year											
3. NAME OF DECEASED (Type or print) William Henry Murphy		First	Middle	4. DATE OF DEATH Month Doy Year	5. SEX Male		6. COLOR OR RACE Cauc	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 MAR 84		9. AGE (in years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Doy Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy, Ret.		10b. KIND OF BUSINESS OR INDUSTRY GMC		11. BIRTHPLACE (County & State, or foreign country) New York, N. Y.		12. CITIZEN OF WHAT COUNTRY? USA													
13. FATHER'S NAME Daniel Joseph MURPHY				14. MOTHER'S MAIDEN NAME Mary E. HOGAN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1905-1922						16. SOCIAL SECURITY NO 578 01 0219		17. INFORMANT Gladys C. MURPHY		Address Same as 2D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE				19. INTERVAL BETWEEN ONSET AND DEATH				20. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
+200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)				DUE TO				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 14 SEP 1967 to 16 DEC 1967 , that (I) (we) last saw the deceased alive on 16 DEC 1967 , and that death occurred at 1840 N. FRUIT , fram causes and on the date stated above.											
22a. SIGNATURE 				22b. DATE SIGNED 17 DEC 67				22c. PHYSICIAN'S NAME (Type) Robert J. Kirney, LCDR, MC, USN						22d. ADDRESS U. S. NAVAL HOSP., BETHESDA, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 20, 1967		23c. NAME OF CEMETERY OR Crematory Arlington National		23d. LOCATION (City or Town) Arlington Virginia		(County) (State)											
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				ADDRESS				25a. REC'D BY REGISTRAR DEC 21 1967		25b. REGISTRAR'S SIGNATURE Robert J. Kirney									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17894

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 10 Days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) d. STREET ADDRESS 14701 Peach Orchard Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital										
3. NAME OF DECEASED (Type or print) ETHEL		First	Middle	Last	4. DATE OF DEATH December 29 1967		Month	Day	Year	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/12/03		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Name		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Walter G. Wright		14. MOTHER'S MAIDEN NAME Anna Duvall								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Medical Records		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION		DUE TO GENERALIZED METASTASIS		INTERVAL BETWEEN ONSET AND DEATH 60 DAYS						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 170X		(b) ARGINOMA, BREAST.		DUE TO ARGINOMA, ENDOMETRIUM -		MONTHS				
(c)						30 Month				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARGINOMA ENDOMETRIUM -										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Aug 1964 to 12/27/67		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Aug 1964 to 12/27/67 , 1967, and that death occurred at II:45 AM causes and on the date stated above.										
22a. SIGNATURE Donald R. Lewis		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/29/67						
22c. PHYSICIAN'S NAME (Type) Donald R. Lewis, M.D.		22d. ADDRESS 700 Cloverly St. Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-1-68		23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		23d. LOCATION (City or Town) (County) (State) Bethesda Md				
24. FUNERAL DIRECTOR Be Witt Donelson Laurel Md		ADDRESS		25a. REC'D. BY REGISTRAR DIAN 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 12 Film G390 1/3/68 kk

✓ 206

CERTIFICATE OF DEATH

17316

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Montgomery MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Holy Cross Hospital			
f. STREET ADDRESS			
Shore Acres			
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
h. NAME OF DECEASED (Type or print)		First	Middle
Rosa			
i. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> / NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
F		W	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
housewife			
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? Italy	
Sicily			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Salvatore Di Pietro		Concetta Giglio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Mr. Joseph DiPietro Shore Acres, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) lost.		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
BILATERAL LOBULAR PNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/21/67 to 12/24/67, that (I) (we) last saw the deceased alive on 12/24/67, and that death occurred at 11 AM, from causes and on the date stated above.			
22. SIGNATURE Richard H. Pollen		22b. DATE SIGNED 12/26/67	
22c. PHYSICIAN'S NAME (Type) Richard H. Pollen MD		22d. ADDRESS 10400 CONNECTICUT AV KENSINGTON MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/28/67	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cemetery
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Witzke D. - 4101 Edmondson Ave.		25a. RECEIVED BY REGISTRAR DEC 26 1967	25b. REGISTRAR'S SIGNATURE DATE

REV.

TEST